THE UNIVERSITY OF ALBERTA

AN INVESTIGATION OF THE LABOUR-MANAGEMENT RELATIONSHIPS IN THE ALBERTA HOSPITAL SYSTEM

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "An Investigation of the Labour-Management Relationships in the Alberta Hospital System," submitted by John Frederick Moriarty in partial fulfilment of the requirements for the degree of Master of Health Services Administration.

ABSTRACT

This is a descriptive study of the labour relations system in the Alberta hospital industry. The study examined the organizational and financial characteristics of the hospital industry, the extent of employer and employee organizations in Alberta hospitals, and the collective bargaining mechanisms that have developed.

The major recommendation of the study for further research was that representatives of the Provincial Department of Health should participate directly in collective bargaining with hospital boards and employees. In addition, the study has outlined areas in the collective bargaining arrangements used in Alberta hospitals that require modification. Finally the study recommends the amalgamation of the paramedical personnel into one bargaining unit.

ACKNOWLEDGEMENTS

I am indebted to a number of persons and institutions for their contributions and assistance. I wish to express my sincere gratitude to the many Associations and Union officials for their candid answers to my many questions. Special thanks are extended to Professor C. A. Meilicke whose encouragement and support made this study possible. I am obligated to Professor R. H. M. Plain who served as an advisor during the study. A final thanks are extended to my parents whose moral and financial support made this study possible.

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CHAPTER I

INTRODUCTION

Unions have begun to emerge as strong forces in the formulation of policies that govern the allocation of resources in the hospital segment of the health care industry. Research into hospital-union relationships in the United States has indicated that:

> Prior to the 1960's, the turbulent waters of Union relations largely bypassed the hospitals... however the economic and political forces that are reshaping the financing of hospital services in the 1970's, and the increasing militancy and expertise of health employee organizations can be expected to have a deteriorating effect on the degree to which health care objectives are attained. [1]

Similar observations in Canada indicate that the questions of unionization and collective bargaining are of considerable concern to both hospital administrators and government.[2] This concern has been stimulated in recent years by the rapid growth of employment in Canadian hospitals and the problems created by militant hospital employees.[3]

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[1] Ronald L. Miller. "The Hospital-Union Relationship," Hospitals, 45 (May 1, 1971), p. 49.

[2] "Prognosis 1964: Labour and the Hospital Dollar in Canada," Hospital Administration in Canada, 5 (October, 1963), pp. 28-36.

[3] Robert A. Wall. "What to do When Your Hospital is on Strike," Hospital Administration in Canada, 12 (June, 1970), pp. 28-30.

EMPLOYMENT TRENDS IN THE HOSPITAL INDUSTRY

I. NATIONAL TRENDS

During the past ten years there has been a continual rise in the proportion of the labour force employed in the service industries in Canada. Table I indicates the magnitude of the relative changes in the distribution and growth of the labour force in various selected industries between 1961 and 1968.

It is evident that there has been a significant increase in both the absolute numbers as well as the percentage of the total Canadian labour force employed in the hospital industry. Table I demonstrates that the total number of employees has increased from 205.1 to 302.9 thousand--a 47.7 per cent increase--while Table II indicates that the percentage of the total labour force employed in Canadian hospitals has increased from 3.14 to 3.82 per cent--an increase of 17.8 per cent over an eight year period.

The growth rate of personnel employed in hospitals has been significantly higher than that of the total civilian labour force. Reference to Table III indicates that the annual growth rate in hospitals has been 2 to 4.5 times as great as the annual increases in the civilian labour force.

UNIONIZATION

As the labour force has increased in numbers and scope, it has been the focus of organizing activity on the part of unions. Table IV indicates that

union membership has increased from 313 thousand in 1921 to over 2 million as of April 1970; however, it should be noted that the percentage of the labour force enrolled in unions has not deviated significantly between 1952 and 1970 (30.2 vis-a-vis 33.6 per cent).[4] At the present time there are no reliable figures published on the percentage of hospital employees that are unionized.[5]

II. PROVINCIAL TRENDS

Since 1961, there has been a continual rise in the proportion of the labour force employed in the service industries in Alberta. Table V indicates that the service industries have experienced the greatest increase in numbers of employees--112.7 thousand in 1968 compared to 71.3 thousand in 1961--an increase of 36.7 per cent. Approximately 5.3 per cent of the total labour force in 1968 was employed in the hospital sector of the service industries--an increase of 40.1 per cent over 1961.[6]

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[4]The recent Task Force on Labour Relations gives no indication why the percentage of the labour force that is unionized stands at only 33 per cent nor why it has remained much the same since 1952. See Canadian Industrial Relations, The Report of Task Force on Labour Relations, Ottawa: Queen's Printer, 1969, pp. 23-25.

[5]The only statistic available that would give any indication of the extent of unionization in hospitals is listed under Health and Welfare. The figure for 1969 is 114,074 union members. See "Union Membership in Canada by Industry and Area," 1969, Labour Gazette (March, 1970), p. 231.

[6]In 1961 there were 12,087 employees in Alberta Hospitals compared to a 1968 total of 20,057. Data obtained from "Annual Reports" of the Alberta Hospitalization Plan. (Alberta: Queen's Printer, 1961 and 1968).

TABLE I

ESTIMATE OF EMPLOYEES BY SELECTED INDUSTRY. CANADA, 1961 - 68

Selected Industry	1961	1962	1963	1964	1965	1966	1967	1968	% change 1961-68
				000					per cent
Manufacturing	1,302.1	1,356.2	1,396.9	1,469.0	1,449.8	1,635.3	1,642.5	1,639.2	25.9
Trade	743.0	772.3	796.8	829.0	872.5	920.2	549.4	984.5	32.5
Transportation, communication and other utilities	571.1	575.4	581.6	598.9	616.4	634.8	652.1	642.3	12.5
Service (commercial sector)	374.5	401.9	420.5	453.1	498.0	545.5	582.1	611.3	63.2
Education	277.9	300.2	323.0	344.2	369.3	402.4	442.9	527.7	89.9
Construction	291.5	305.0	306.0	323.0	356.6	379.6	363.4	361.3	23.9
General and allied special hospital	205.1	218.0	230.0	243.7	258.4	272.9	291.1	302.9	47.7
Service (non commercial sector)	207.7	205.1	219.1	229.8	236.4	237.8	251.4	237.4	14.3
Finance, insurance and real estate	194.8	205.4	218.1	229.9	238.9	248.8	265.6	280.7	44.1
Mines, quarries and oil wells	106.7	108.1	106.4	107.5	114.2	116.8	118.5	120.4	12.8
Forestry	68.4	70.2	68.2	71.1	71.7	72.6	71.1	64.5	-5.7

Source: Estimates of Employees by Province and Industry (Catalogue No. 72-508), Employment Section, Labour Division, DBS. 1968.

TABLE II

TOTAL PERSONNEL EMPLOYED IN HOSPITALS AS A PERCENTAGE OF THE CIVILIAN LABOUR FORCE, CANADA, 1961-68

Year	Total hospital personnel	Total civilian labour force	Hospital personnel as % of civilian labour force
	000		%
1961	205	6.521	3.14
1962	218	6.615	3.30
1963	230	6.748	3.41
1964	244	6.933	3.51
1965	258	7.141	3.62
1966	273	7.420	3.68
1967	291	7.694	3.78
1968	303	7,919	3.82

Source: Labour Division, DBS. Canada, 1968.

TABLE III

ANNUAL PERCENTAGE INCREASE IN TOTAL HOSPITAL AND CIVILIAN LABOUR FORCE, CANADA, 1961-68

Year	Total hospital personnel	Total civilian labour force
	per cent	
1961 - 62	6.3	1.4
1962 - 63	5.5	2.0
1963 - 64	6.0	2.7
1964 - 65	6.0	3.0
1965 - 66	5.6	3.9
1966 - 67	6.7	3.7
1967 - 68	4.0	2.9
1961 - 1968	47.7	21.4

Source: Labour Division, DBS.

TABLE IV

UNION MEMBERSHIP AS A PERCENTAGE OF THE NON-AGRICULTURAL LABOUR FORCE IN CANADA
Selected Years 1921 - 1970

Year	Union Members	Total Non-Agricultural Paid Workers	Union Members as a Percentage of Non-Agricultural Paid Workers
	(Thousands)	(Thousands)	
1921	313	1,956	16.0
1926	275	2,299	12.0
1931	311	2,028	15.3
1936	323	1,994	16.2
1941	462	2,566	18.0
1946	832	2,986	27.9
1951*	1,029	3,625	28.4
1952	1,146	3,795	30.2
1953	1,220	3,694	33.0
1954	1,268	3,754	33.8
1955	1,268	3,767	33.7
1956	1,352	4,058	33.3
1957	1,386	4,282	32.4
1958	1,454	4,250	34.2
1959	1,459	4,375	33.3
1960	1,459	4,522	32.3
1961	1,447	4,578	31.6
1962	1,423	4,705	30.2
1963	1,449	4,867	29.8
1964	1,493	5,074	29.4
1965	1,589	5,343	29.7
1966	1,736	5,658	30.7
1967	1,921	5,953	32.3
1968	2,010	6,100	33.1
1969	2,075	6,530	32.5
1970	2,173	6,465	32.6

*Includes Newfoundland from 1951

Source: Canada Department of Labour Economics and Research Branch, Labour Organizations in Canada, (Ottawa, Queen's Printer, 1970), p. xiii.

UNIONIZATION

It is evident from Table VI that the annual increase in hospital personnel has been greater than that experienced by the non-agricultural portion of the labour force. The percentage of the Alberta labour force enrolled in unions is considerably below the national average (21.9 versus 33.1 per cent in 1968)[7] Unfortunately, no reliable data has been published which can be used as a basis for establishing the degree of unionization in the Alberta hospital industry.[8]

PURPOSE

The purpose of this study is to examine selected aspects of the labour relations system operating in the Alberta hospital industry. This examination will include: (1) a description of the industry; (2) an investigation of the type of Unions that have developed; and (3) an examination of the

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[7] Information obtained from "Industrial and Geographic Distribution of Union Membership in Canada," Labour Gazette, (March, 1969), p. 167.

[8] A very general indication of the extent of unionization in Alberta Hospitals is presented in E. H. Knight, "Alberta's Province-wide Bargaining Program Now the Most Extensive in Canada," Hospital Administration in Canada (March, 1968), p. 53.

TABLE V

ESTIMATE OF EMPLOYEES BY SELECTED INDUSTRY, ALBERTA, 1961-68
(in thousands)

Selected Industry	1961	1962	1963	1964	1965	1966	1967	1968	% change 1961-68
Forestry	2.2	2.5	2.5	2.4	2.6	2.5	2.2	1.8	-22.22
Mines and Oil Wells	16.6	16.9	16.2	16.9	17.7	18.5	19.1	20.0	20.57
Manufacturing	36.7	38.0	40.6	42.1	45.4	49.7	51.9	30.8	27.76
Construction	25.4	26.9	25.3	26.3	30.9	33.1	35.5	32.4	21.60
Transportation	43.3	44.5	45.4	47.2	47.5	48.4	49.5	46.6	7.08
Trade	57.3	59.2	61.3	63.5	67.6	72.6	74.6	74.7	23.29
Finance, Insurance and Real Estate	11.6	12.5	12.7	13.9	13.5	14.2	15.8	16.0	21.25
Services*	71.3	74.3	79.2	84.9	90.9	98.4	109.6	112.7	36.73
Public Administration	17.6	18.0	17.2	17.3	18.2	18.9	20.9	20.9	15.78
TOTAL	282.0	293.3	300.4	313.8	333.8	357.3	379.1	376.8	25.15

*Includes health services and hospitals, education, and recreational services.

Source: Department of Labour (Report No. 72-008), Dominion Bureau of Statistics 1968.

TABLE VI

ANNUAL PERCENTAGE INCREASE IN TOTAL HOSPITAL PERSONNEL AND CIVILIAN LABOUR FORCE, ALBERTA, 1961-68

Year	Total Hospital Personnel[1]	Total Civilian Labour Force[2]
	per cent	
1961 - 62	12.8	3.8
1962 - 63	5.1	2.3
1963 - 64	7.0	4.4
1964 - 65	3.2	5.8
1965 - 66	10.8	6.8
1966 - 67	6.4	1.4
1967 - 68	6.6	3.9
1961 - 68	39.7	25.1

Source: [1]Annual Reports, Alberta Hospitalization Plan, 1961 - 68.

[2]Department of Labour (Report No. 72-008), Dominion Bureau of Statistics, 1961 - 68.

collective bargaining processes that are used.[9]

SCOPE

Given the magnitude and diversity of the labour force employed in the hospital industry, this study will concentrate on describing the experience of three main categories of employees: (1) a professional class of registered nurses, dietitians, occupational and physical therapists as well as some highly trained technicians, and medical record librarians; (2) a semi-professional class--workers who have technical training in laboratories and in the operation of diagnostic equipment such as X-Ray machines; and

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[9]At the present time the articles available on the topics of unionization and collective bargaining are rather limited in scope and depth. A representative selection of available articles are listed below:

A. L. Swanson. "Labour Legislation and Union Negotiations," Canadian Hospital, 38 (March, 1961), p.38.

J. Crisp. "Collective Bargaining and the Professional," Canadian Hospital, 40 (June, 1963), pp. 47-49.

"Comparisons of Provincial Labour Negotiations," Canadian Hospitals, 44 (May, 1967), pp. 55-56.

G. W. Reed. "Unions Come to Hospitals," Canadian Hospitals, 33 (January, 1956), p. 334.

B. McCarthy. "Collective Bargaining: The Experience of Hospitals in Ontario," Canadian Hospitals, 39 (May, 1962), p. 38.

R. L. Miller. "Collective Bargaining in Hospitals," Hospital Administration, 12 (Summer, 1967), pp. 60-68.

(3) a non-professional class--the auxiliary nursing, housekeeping, kitchen and clerical staff.

This study will be restricted to the analysis of the experience of these selected groups, the legislation to which they are subject, the resistance they have encountered in organizing, and the collective bargaining mechanisms that have evolved.

FORMAT

This thesis is divided into four chapters. Chapter II consists of an examination of the organizational structure and financial characteristics of the Alberta Hospital industry. Chapters III and IV deal with certain major aspects of the labour-management system in Alberta hospitals. Chapter III describes the management and employee organizations, their structure and the rationale underlying the formation of their respective associations. Chapter IV consists of an explanation of the collective bargaining relationships that have developed. Chapter V presents the summary and concluding observations along with suggested areas for further research.

CHAPTER II

AN OVERVIEW OF THE HOSPITAL INDUSTRY IN ALBERTA

The hospital industry, while similar in many respects, has characteristics which distinguish it from other industries. Since this study is concerned with labour management relations in Alberta hospitals, it is important to identify those characteristics of the industry which influence labour management relations and cause the relations in hospitals to differ from those in other industries.

I. THE RESPONSIBILITIES FOR HOSPITAL SERVICE

It is not easy to establish the line of demarcation between the social and financial responsibilities of the individual for his own hospital care and the responsibilities of the three levels of government. The boundary is shifting, not only away from the individual, but from the municipal to the provincial government and in certain areas from the provincial to the federal government.

THE RESPONSIBILITIES OF THE FEDERAL GOVERNMENT

Traditionally and constitutionally, health services have developed for the most part within a provincial jurisdiction.[1] This attitude is reflected

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[1]The Federal Government is required to provide health care services including hospital services to the armed forces, veterans, Indians, mariners and Eskimos.

in the British North America Act (hereafter referred to as the B. N. A. Act) which makes no specific mention of public health responsibilities.[2] Health, at the time of Confederation, was viewed as being largely a personal matter--with some exceptions such as the control of epidemics, sanitary conditions, and the care of the insane. In Section 91 of the B.N.A. Act, the Federal Government was given the responsibilities for quarantine regulations and the establishment and maintenance of marine hospitals. The provinces were responsible for "the establishment, maintenance, and management of hospitals, asylums, charity and eleemosynary institutions in their respective provinces."[3] As a consequence, since the time of Confederation, the major responsibility for hospital services has rested within provincial jurisdiction.[4]

It was not until 1955, at a Federal-Provincial Conference, that the Federal Government was willing to discuss the provision of substantial

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[2]A review of the evolution of organized community health services in Canada can be found in J. E. F. Hastings, Organized Community Health Services, a study prepared for the Royal Commission on Health Services (Ottawa: Queen's Printer, 1964), pp. 1-8.

[3]Government of Canada, The British North America Act (Ottawa: King's Printer, 1867), Sec. 92 (7).

[4]An excellent discussion of federal and provincial responsibilities for health can be found in A. E. Greer, "A Public Health Study," prepared for the Royal Commission on Dominion-Provincial Relations (Ottawa: King's Printer, 1939), pp. 4-16.

financial assistance to the provinces for the operation of their hospitals.[5] Early in 1956, a federal program of technical support and financial assistance to provincially administered insurance programs covering hospital care and diagnostic services was proposed. These proposals were incorporated in the terms of the Hospital Insurance and Diagnostic Services Act (hereafter referred to as H.I.D.S.) enacted in 1957.

The H.I.D.S. Act represents an undertaking by the Federal Government to share the cost of provincially administered programs, providing for prepayment of the basic costs of active treatment and chronic care in approved hospitals. Under the formula laid down by the H.I.D.S. Act, the annual federal contribution for a province is the sum for that year of 25 per cent of the national per capita cost of in-patient services plus 25 per cent of the per capital cost of in-patient services in the province, multiplied by the population in the province.

Under the H.I.D.S. Act, the effect of the formula is to vary the proportion of the cost met by the Federal Government in each province. A province with a low per capita cost receives more than 50 per cent of its costs, while a province with a high per capita cost, receives less than 50 per cent.[6]

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[5]Until 1952, the Federal Government provided a yearly average of 10 million dollars to the Provinces for hospital construction. See Eric Hanson, The Public Aspects of Health Services in Canada (Ottawa: Queen's Printer, 1964),

[6]For more information on the Hospital Insurance & Diagnostic Services Act, see Health Services in Canada (Toronto: Mutual Press Ltd., 1965).

For example, in 1967, Alberta received $28.28 per person--approximately 48.8 per cent of its hospital costs.[7]

THE RESPONSIBILITIES OF THE PROVINCIAL GOVERNMENT

Since 1905, the Province of Alberta has assumed responsibilities for the provision of hospital services to the residents of the Province.[8] This responsibility was initially vested in the Provincial Department of Agriculture and was subsequently transferred to the Provincial Secretary and then to the Department of Municipal Affairs. In 1919 the Department of Public Health Act was passed and Alberta became the second province in Canada to establish a Department of Health.[9]

As the population of Alberta has grown and the services of the Department of Health have developed--health accounts for approximately 20 per cent of the provincial budget (see Figure 1), the organization has become more complex. The organization of the department is unique for

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[7] Annual Report, Hospital Insurance and Diagnostic Services Act (Ottawa: Queen's Printer, 1969), Table F, p. 57.

[8] For a detailed discussion of the history of the Department of Health in Alberta, see R. D. Defries, et.al., The Federal and Provincial Health Services (Toronto: University of Toronto Press, 1962), pp. 109-122.

[9] Saskatchewan was the first Province in Canada to establish a Department of Health (1909).

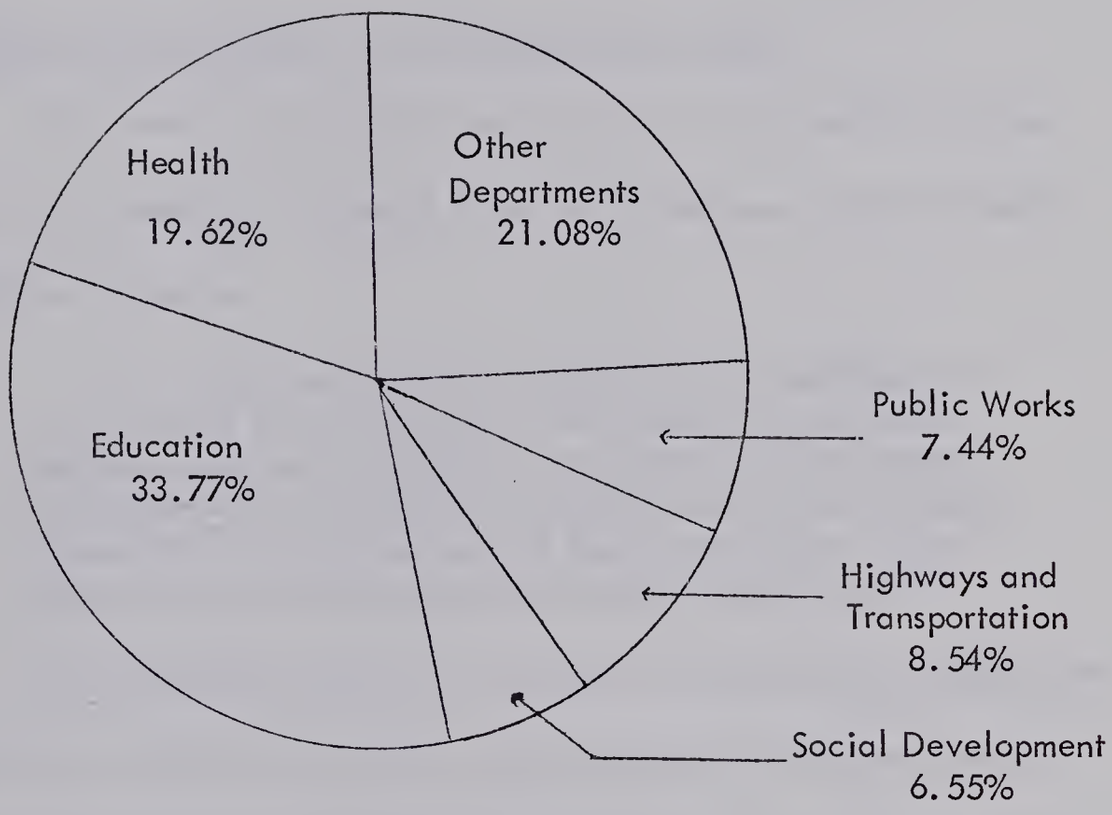

FIGURE I

PERCENTAGE OF ESTIMATED EXPENDITURE
BY MAJOR DEPARTMENTS FOR FISCAL
YEAR ENDING MARCH 31, 1971

Source: Budget Speech, Delivered at the Third Session of the Sixteenth Legislature in Alberta, 1970.

departments of the Alberta Government (note the organization chart on page 19).[10] There are two Deputy Ministers, one responsible for the hospital services section while the other is in charge of the general activities of the Department.

The Hospital Services Section of the Department of Health

The primary responsibility and function of the Hospital Services Section of the Department of Health is set out in the Department of Health Act (1967) which states:

> The Department shall be divided into two sections: A. The Hospital Services Section, which shall be responsible for the operation of programs to be provided for the people of Alberta under the Alberta Hospitals Act and The Nursing Homes Act or such other parts of them as the Minister may desire and such other programs as the Minister directs.[11]

The duties and powers of the Hospital Services Section include the approval of the location and construction of hospitals; the determination, approval and maintenance of adequate standards of service rendered within a hospital; the provision of consulting services to individual hospitals when requested; the inspection of hospitals; the paying of hospitals for insured

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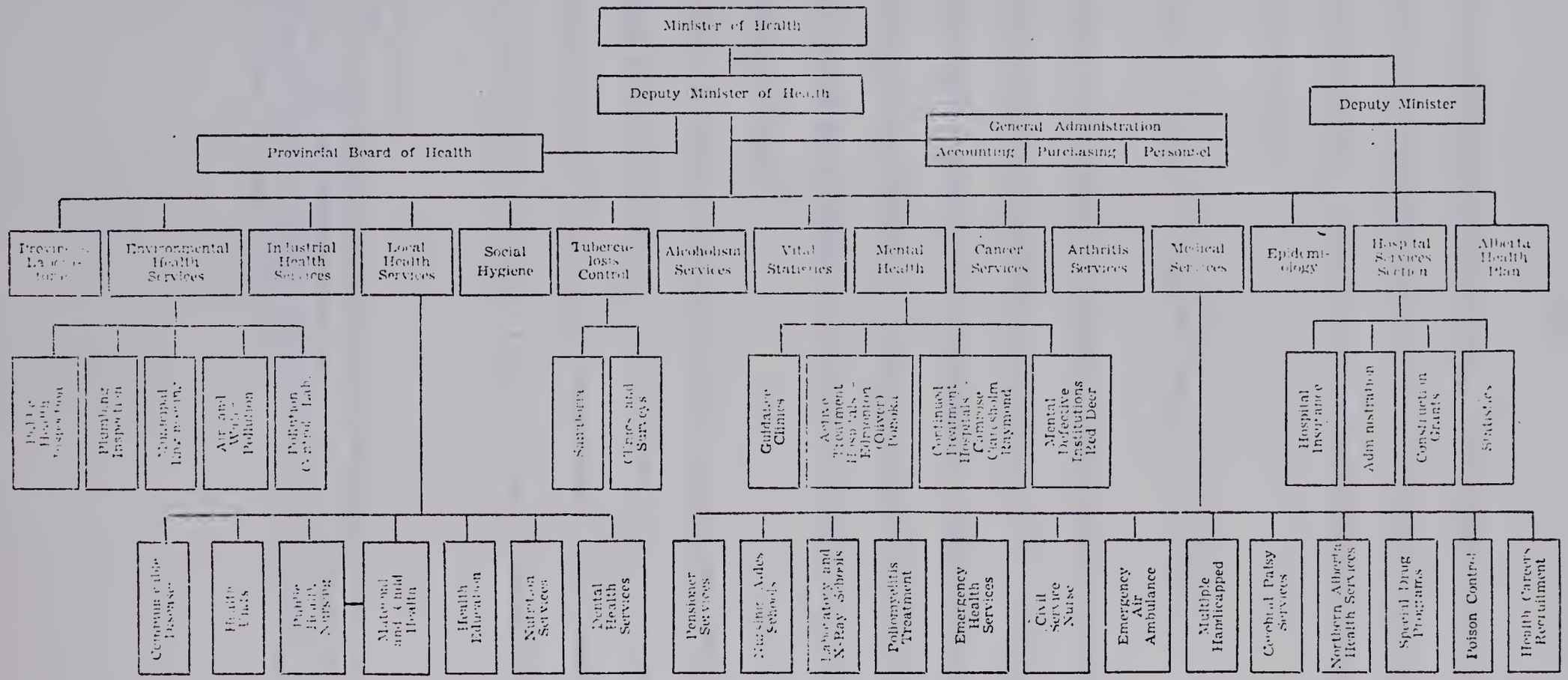
[10]The Statutes which the Department of Health is responsible for are listed in Appendix I.

[11]Alberta. The Department of Health Act (Edmonton: Queen's Printer, 1962).

FIGURE II

Department of Health—Alberta
DIVISIONAL ORGANIZATION

December – 1968



services; the administration and enforcement of the Alberta Hospitals Act and Regulations; and the administration of the agreement with the Government of Canada respecting contributions under the Hospital Insurance and Diagnostic Services Act.

THE RESPONSIBILITIES OF THE MUNICIPAL GOVERNMENTS

Since Alberta became a province in 1905, hospital facilities have been organized primarily as a result of the initiative of the residents. Many of the original hospitals were built and operated by religious groups and most of these were established because of a community demand for health services. The funds to operate these early hospitals were obtained almost entirely from the local property owners.[12]

Over the years, as hospital services expanded and costs increased, the percentage of funds contributed to local hospitals by the Province increased. The local hospital boards, while grateful for the funds, experienced some misgivings about government financing. They found controls were being imposed

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[12] In 1923 municipal hospitals received a grant from the Alberta Government of $.50 per patient day to help defray the average daily cost of hospital care of $3.12. Annual Report, Department of Public Health (Edmonton: Queen's Printer, 1923), p. 27.

on the types of services they could provide and the amount of funds they could spend.[13] Although this method of financing has somewhat restricted the freedom of the local hospitals' boards, it has enabled the Province to rationalize patient care services in Alberta to a limited degree.[14]

II. HOSPITAL OWNERSHIP IN ALBERTA

Although the major responsibilities for hospital services rests with the Provincial Government, the actual ownership is assumed by a number of groups. In order to describe the various ownership arrangements that have developed in Alberta hospitals, the description shall be divided into four categories: (1) Federal Hospitals; (2) Provincial Hospitals; (3) Municipal Hospitals; and (4) Voluntary Hospitals. This description will facilitate the examination of the collective bargaining processes used in the Alberta hospital industry.

1. Federal Hospitals

There are eight Federal Government hospitals operating in Alberta

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[13]For a discussion on the role of hospital boards in Alberta under a government reimbursement scheme, see: Report of the Expenditure and Revenue Study Committee (Alberta: Queen's Printer, 1965), p. 26.

[14]Part 3 of the Alberta Hospitals Act defines what patient care services in Alberta hospital shall mean. In addition, Section 57, parts a-j, outline the specific regulations under which active treatment and auxiliary hospitals shall operate. Specifically the Lieutenant Governor in Council may prescribe which services, in addition to standard ward hospitalization that may be provided by a hospital in Alberta. The Alberta Hospitals Act (Edmonton: Queen's Printer, 1961), Section 57 s.s. (b).

(see Table VII). The authority to own and operate the Federal Hospital is outlined in the Act to Establish the Department of National Health and Welfare.[15] These hospitals are reimbursed by the Alberta Department of Health for services provided to residents of the Province other than those covered by the Federal Government. The remaining costs for operating the hospitals is the responsibility of the Dominion Government.

The Colonel Belcher Hospital in Calgary is administered by the Department of Veterans Affairs and provides in-patient and out-patient services to war veterans. The remaining seven hospitals[16] are administered by the Directorate of Indian Health Services of the Department of National Health and Welfare. These hospitals provide acute care services to the Indian and Eskimo residents of Alberta.[17]

2. Provincial Hospitals

There are four provincial hospitals dealt with in this paper whose operations are under the scrutiny of the Alberta Hospital Services Division.

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[15]Canada, The Department of National Health and Welfare Act (Ottawa: King's Printer, 1944).

[16]The seven hospitals are: Cardston Blood Indian Hospital; Charles Camsell in Edmonton; Gleichen Blackfoot Indians and Medley Hospitals; and Outpost Nursing Stations at Fort Chipewyan, Fox Lake and Hay Lakes.

[17]Information obtained from: Department of National Health & Welfare, Hospital in Canada (Ottawa: Research Division of Health and Welfare, 1955), pp. 58-60.

TABLE VII

ALBERTA HOSPITALS BY TYPE OF OWNERSHIP

Federal Hospitals	8
Provincial General Hospitals	4
Municipal General Hospitals	81
Municipal Auxiliary Hospitals	22
Voluntary General Hospitals	33
Voluntary Auxiliary Hospitals	6
Contract Hospitals	2
TOTAL	156

Source: Annual Report of the Alberta Hospitalization Benefits Plan (1969).

(See Appendix IV in the thesis for definitions of hospitals).

The four hospitals are the University Hospital in Edmonton, subject to the Act respecting the University of Alberta Hospital,[18] the Foothills Hospital in Calgary and the Glenrose Hospital in Edmonton, subject to the Provincial General Hospitals Act,[19] and the W. W. Cross Cancer Hospital in Edmonton.[20] These four hospitals are dependent upon the Provincial Government for their operating and capital funds; however, the hospitals maintain complete responsibility for their day to day operations.

3. Municipal Hospitals

There are presently 103 municipally owned hospitals in Alberta. Active treatment hospitals, which are primarily designed to provide short-term hospitalization, account for 81 of the municipal hospitals. In addition

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[18]Alberta, The University Hospitals Act (Edmonton: Queen's Printer, 1955), Section (5) and Section (6) (1-4) outlines (1), the composition of the board which shall total nine members and (2), the duties of the board.

[19]Alberta. The Provincial General Hospital Act (Edmonton: Queen's Printer, 1969), Section 3 (1.2) and Sections 7 and 9. Section 3 (1.2) outlines the authority of the Lieutenant Governor in Council to establish two provincial general hospitals; one in Calgary and the other in Edmonton. Sections 7 and 9 outline the compositions and duties of the ward.

[20]Alberta. The Cancer Treatment and Prevention Act (Edmonton: Queen's Printer, 1967), Section 6 (1-3) and Sections 7-9. Section 6 outlines the authority of the Lieutenant Governor in Council to establish a Cancer Hospital, Sections 7 - 9 outline the composition of the board and their duties.

there are 22 auxiliary hospitals owned by municipalities in Alberta.[21]

Under the Alberta Hospital's Act, all municipal hospitals are to be operated by elected boards of management.[22] This arrangement is designed to serve as a stimulant to the local community to provide efficient management for the operation of its hospital.

According to Part I, Section 3, Subsection (1) of the Alberta Hospitals Act (1966) the Minister of Health may designate an area around a municipal hospital which will be responsible for a portion of the capital and operating costs of the municipal hospital. These general hospital districts are responsible for approximately 8 per cent of the hospital costs within their district (Section 14 of the Hospitals Act).[23] In addition the hospital board may

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[21]The auxiliary or chronic hospital program is a relatively new undertaking which was begun in 1959. The purpose of the auxiliary hospital is to care for patients requiring hospital treatment of a less intensive nature than is provided for in acute care hospitals. Attention is focussed mainly on patients requiring active rehabilitation of a long term nature. See, E. H. Knight, "Care of Chronically Ill an Integral Part of Alberta's Comprehensive Hospital Plan." Hospital Administration in Canada, (February, 1969), pp. 43-46.

[22]Each approved hospital shall have a governing board and subject to any limitations of its authority imposed by Acts of the Legislature and regulations thereunder, the board has full control of that hospital and has absolute and final authority in respect of all matters pertaining to the operation of the hospital. Part II, Section 25, The Alberta Hospitals Act, 1964.

[23]Section 14 of the Hospital Act outlines the procedures whereby a hospital board is able to obtain monies to a maximum of 4 mills from the municipalities within the hospital district.

requisition the municipalities within the hospital district for "unapproved costs" which the Hospital Services Division will not cover.[24] The remaining costs of operating the municipal hospitals come from the patient and the Provincial Government.

4. Voluntary Hospitals

Voluntary hospitals refer to the hospitals in Alberta that were built prior to 1964 and which are owned by voluntary associations or religious groups. In Alberta there are 28 active treatment hospitals owned by Roman Catholic Orders, five active treatment hospitals owned by voluntary groups and six voluntary auxiliary hospitals.

Voluntary hospitals in Alberta, although financed by the Provincial Government for all approved operating costs, do not have access to the four-mill hospital tax levy as is the case for municipal hospitals. Provision is made, however, in the Alberta Hospitals Act for co-operative action between the

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[24] Unapproved cost means the audited operating cost of an approved hospital over and above the approved operating cost recognized by the Hospital Services Division. Section 53 below outlines the procedure whereby a hospital may obtain the monies necessary to cover unapproved costs.

> "A municipality or a hospital district shall provide out of its general revenue and pay to the board of a hospital, any portion of the operating or capital costs of that hospital in excess of the amount of such costs, which have been approved and paid by the Minister: (a) if that hospital is owned or operated by that municipality or by that hospital district, or (b) to the extent provided by the terms if any contract made pursuant to this Act between that municipality or hospital district and the board of management of that hospital"

Alberta, The Alberta Hospitals Act (Edmonton: Queen's Printer, 1964), Sec. (53), p. 164.

voluntary owners and the municipalities in which the voluntary hospital is located. This provision allows the owners to obtain operating funds from the hospital district.

> (1) Where a hospital district is served by a non-district voluntary hospital, the owners of the hospital may enter into an agreement (a) with the district board, or (b) with any one or all of the councils of the included municipalities, covering unapproved costs.[25]

III. FINANCIAL AND ECONOMIC CHARACTERISTICS OF ALBERTA HOSPITALS

GENERAL

It is generally stated that hospital costs are closely related to many of the labour management problems encountered in the hospital industry.[26] Since 1958 hospital services costs in Canada have increased from 42.3 per cent to 49.3 per cent of the total money spent on health care (See Figure III, page 28). Costs in Alberta hospitals for 1968 show an increase of 913.8 per cent over 1950. (Table VIII, page 29). The per patient day cost in 1950 was $7.96 compared to costs per patient day of $47.93 in 1969.

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[25] Alberta, The Alberta Hospitals Act, op.cit., Section 2.

[26] Leo B. Osterhaus, "The Effect of Unions on Hospital Management," Hospital Progress (June, 1967), p. 69 and Max Brown, "An Economic Analysis of Hospital Operation," Hospital Administration, XXD (Spring, 1970), pp. 60-74.

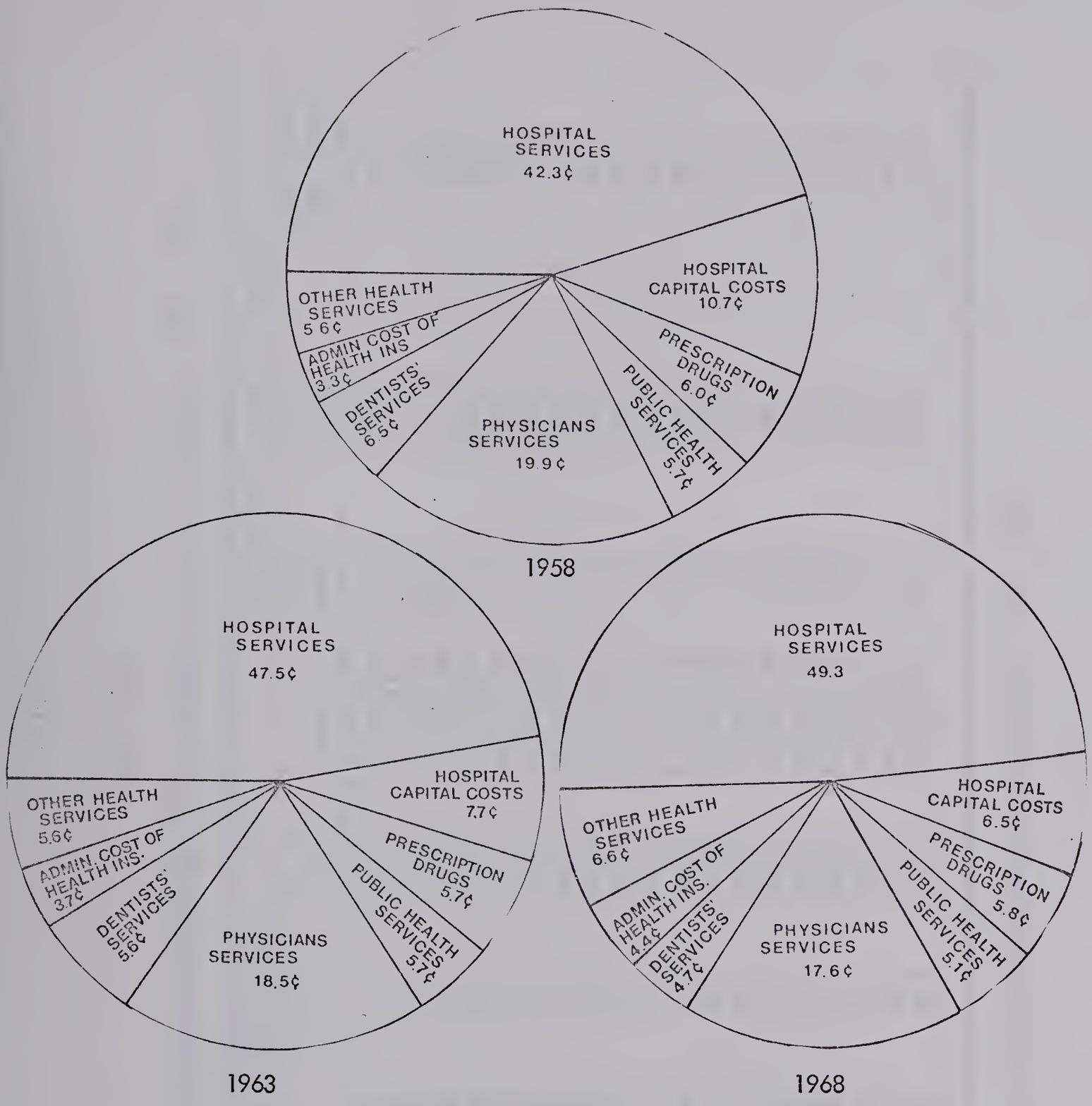

FIGURE III

BREAKDOWN OF THE HEALTH DOLLAR
FOR CANADA - 1958, 1963, 1968

Source: Canadian Medical Journal, September 12, 1970, p. 562.

TABLE VIII

INCREASE IN GROSS EXPENDITURES OF GENERAL HOSPITALS IN ALBERTA, 1950 - 1968

	TOTAL GROSS EXPENDITURES			SALARIES AND WAGES			
Year	Amount	% Yearly Increase	% of 1950	Amount	% Yearly Increase	% of 1950	% of Total Expenditure
1950	$ 13,266,925	-	100.0	$ 6,462,998	-	100.0	48.7
1951	50,060,818	13.5	113.5	7,486,069	15.8	115.8	49.7
1952	17,188.076	14.1	129.6	9,032,252	20.7	139.8	52.5
1953	20,946,669	21.9	157.9	11,431,916	26.6	176.9	54.6
1954	24,015,942	14.7	181.0	13,778,991	20.5	213.2	57.4
1955	26,070,752	8.6	196.5	14,985,622	8.8	231.9	57.5
1956	28,684,797	10.0	216.2	16,986,490	13.4	262.8	59.2
1957	32,261,054	12.5	243.2	19,906,876	17.2	308.0	61.7
1958	35,475,327	10.0	267.4	22,356,146	12.3	345.9	63.0
1959	41,962,959	16.3	316.3	26,330,439	17.6	406.6	62.6
1960	45,726,082	9.0	344.6	28,653,188	9.0	443.3	62.7
1961	48,155,466	5.3	363.0	31,188,373	8.8	482.6	64.8
1962	54,471,471	13.1	410.6	34,235,008	9.8	529.7	62.9
1963	59,969,313	10.1	452.0	37,990,970	11.0	587.8	63.4
1964	65,731,477	9.6	495.5	41,802,790	10.0	646.8	63.6
1965	72,136,626	9.7	543.7	46,261,996	10.7	715.8	64.1
1966	85,011,681	17.8	640.8	53,588,688	15.8	829.2	63.0
1967	102,958,793	21.1	776.1	66,182,628	23.5	1,024.0	64.3
1968	121,232,805	17.7	913.8	79,378,671	19.9	1,228.2	65.5
1969	134,459,864	10.9	1,100.2	90,783,258	18.2	1,542.5	67.5

Source: Annual Reports, Alberta Department of Public Health, 1950 - 1969.

Reference to Table VIII indicates that the proportion of the total cost represented by labour costs has increased from 48.7 per cent in 1950 to 67.5 per cent in 1969--an increase in 18 years of 28 per cent. With such large increases in expenditures on hospital services and the consequent increase in labour costs, it is important to outline the methods by which hospitals are reimbursed for their expenditures.

The cost of operating hospitals in Alberta is provided for under the Alberta Hospitals Act and is shared by the patients, the owners of the hospitals, the municipalities, the Province of Alberta, and the Federal Government. The distribution of the cost of hospitalization in Alberta for 1969 is outlined in Table IX.

The portion of the cost which is the patient's responsibility is represented by the annual premiums that are payable by him.[27] The owner's responsibility represents amounts which are ultimately met by the municipalities, either as owners of the hospital or through agreement with the owners of the hospitals. The share of hospital costs borne by the Province of Alberta is a residual share and reflects changes in the overall cost of the plan as well as changes in the relationship in the share borne by patients, by municipalities

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[27]Refer to The Health Insurance Premiums Act (Edmonton: Queen's Printer, 1969) which outlines the regulations in regard to the payment of an annual premium.

TABLE IX

TOTAL COST OF HOSPITALIZATION
IN ALBERTA
1969

	$	%
Patient's Share	$ 19,317,658	11.5
Owner's Share (including Municipal 4-mill levy)	16,687,092	10.0
Provincial Government	63,759,316	38.0
Federal Government	67,947,850	40.5
TOTAL	$167,711,916	100.0

Source: Annual Report of the Alberta Hospitalization Benefits Plan 1969, p. 13.

and by the federal government.[28]

The hospitals have access to additional funds in the form of municipal grants and/or private donations, but these provide a limited source of income. In practice, few hospitals can actually augment the levels of income approved by the Province. Nevertheless, hospitals, as autonomous bodies are free to provide services and make expenditures beyond the standards set by the Province. These expenditures however, are not met by the government and have to be paid for by the hospitals themselves.[29]

FACTORS INFLUENCING HOSPITAL OPERATING COSTS

There are three major factors governing hospital operating costs. These factors consist of: (1) the extent of services provided by a hospital to its patients; (2) the wages and salaries paid to the labour inputs required to produce the services; and (3) the manner in which hospitals are utilized--i.e., the admission rate per 1,000 population and the average length of stay of a patient in a hospital.

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[28]Information obtained in an interview with Mr. Foster, Hospital Services Section, Alberta Department of Health, September, 1970.

[29]M. G. McCallum, "Alberta Provincial-Municipal Hospitalization Plan," Canadian Journal of Public Health, 47 (April, 1956), pp. 142-146.

SERVICES PROVIDED BY A HOSPITAL

Hospital operating costs can be separated into two broad categories; general services cost and patient services cost. The primary purposes of the general services functions are to manage the hospital's business activities and to provide the "hotel-like" services in the hospital. The areas of the hospital included in the general services are the administrative and business offices, the laundry, kitchen, housekeeping and maintenance departments. In 1968, the general services cost amounted to $20.65 per patient day.[30]

The purposes of the patient services function are to diagnosis and treat the conditions of the sick and injured. The hospital departments included in the patient services function are the nursing department, pharmacy, laboratory, radiology, physical and occupational therapy, medical records, operating and delivery suites and the emergency departments. The cost for providing the patient services function in 1968 was $22.99.[31]

Hospitals are increasing their volume and scope of services in the patient services area. These increases in services are a response to modern medical technology and higher consumer demand. Consistent with this increase in patient services has been an increase in the staff employed by hospitals. (Table X, page 34).

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[30]Information calculated from data in the Annual Report of the Alberta Hospitalization Benefits Plan (Edmonton: Queen's Printer, 1968), p. 41.

[31]Annual Report, op. cit., p. 41.

TABLE X

NUMBER OF PERSONNEL IN ACTIVE TREATMENT AND AUXILIARY HOSPITALS IN ABLERTA - 1960-1969

Category of Personnel	NUMBER OF HOSPITALS 124 1961	128 1962	134 1963	142 1964	143 1965	152 1966	150 1967	155 1968	156 1969	% change over 1961
Hospital Administrators With University degree or diploma in hospital administration						8	4	6	7	
Extension course in hospital administration	18	18	19	27	21	49	54	68	72	
Medical degree	2	2	3	3	5	5	3	4	5	
Registered Nurse	50	56	59	49	45	21	25	20	22	
Other	21	29	29	38	48	36	33	26	27	
TOTAL	91	105	110	117	119	119	119	124	132	31.06
Paid Medical Staff Medical Superintendents	3	2	4	4	4	4	4	3	3	
Radiologists	12	17	16	17	14	19	20	29	27	
Pathologists	9	11	9	12	12	12	16	18	18	
Resident Interns	151	163	156	182	189	208	239	324	356	
Other	11	12	16	15	13	17	18	20	22	
TOTAL	186	205	201	230	232	265	297	394	427	56.44

TABLE X (continued)

Category of Personnel	NUMBER OF HOSPITALS 124 1961	128 1962	134 1963	142 1964	143 1965	152 1966	150 1967	155 1968	156 1969	% change over 1961
Other Professional and Technical Personnel										
Assistant Hospital Administrator	11	8	18	21	25	25	26	58	31	
Dietitians	49	56	57	68	49	47	53	55	58	
Medical Records Librarians	51	85	85	83	57	56	52	54	56	
Laboratory Technitians	292	389	336	276	238	244	260	292	321	
Radiology Technitians	146	176	162	153	143	132	147	186	211	
Combined Laboratory and Radiology Technitions	51	107	69	71	87	94	62	63	63	
Physiotherapists	52	57	70	92	81	99	127	87	152	
Occupational Therapists	10	12	13	23	17	23	30	41	43	
Pharmacists	31	32	33	43	35	42	41	48	58	
Psychologists	2	3	3	2	5	5	10	11	12	
Social Workers	8	6	9	12	13	14	16	19	27	
Other special Service	57		292	379	662	914	1,052	1,210	1,221	
TOTAL	760	871	1,147	1,222	1,410	1,697	2,050	2,094	2,273	66.56

TABLE X (continued)

Category of Personnel	NUMBER OF HOSPITALS									% change over 1961
	124 1961	128 1962	134 1963	142 1964	143 1965	152 1966	150 1967	155 1968	156 1969	
Nursing Department Personnel										
Directors of Nursing	345	112	131	145	152	153	160	292	200	
Supervisors		145	156	190	197	219	252			
Head Nurses	332	286	321	335	225	359	370			
Assistant Head Nurses		119	144	143	135	139	150			
Graduate Nurses Instructors		141	137	145	152	166				
Graduate Nurses General Duty	1,901	1,811	1,970	1,981	2,083	2,300	3,869	4,215	4,362	
Graduate Nurses Other	145	276	254	359	320	340				
Student Nurses	1,789	1,852	1,865	1,812	1,811	2,027	2,144	2,140	1,941	
Qualified Nursing Assistants	1,149	1,427	1,488	1,755	1,821	1,965	1,966	2,149	1,942	
Orderlies	278	375	566	603	464	529	504	511	358	
Other	878	1,362	1,458	1,651	1,989	2,085	2,051	2,100	2,234	
TOTAL	6,954	8,097	8,590	9,129	9,449	10,282	10,846	11,407	10,937	36.41

TABLE X (continued)

Category of Personnel	NUMBER OF HOSPITALS 124 1961	128 1962	134 1963	142 1964	143 1965	152 1966	150 1967	155 1968	156 1969	% change over 1961
Other Personnel										
Administration	614	640	683	686	694	837	959	1,149	1,252	
Dietary	1,100	1,431	1,434	1,530	1,554	1,707	1,567	1,826	2,126	
Laundry	448	511	472	554	566	602	538	594	678	
Linen	103	107	110	114	117	230	113	136	153	
Housekeeping	1,057	1,213	1,178	1,151	1,167	1,217	1,276	1,488	1,523	
Plant Operation and maintenance	379	397	425	489	483	532	511	603	630	
Other	395	40	9	11	11	13	25	22	40	
TOTAL	4,096	4,367	4,301	4,535	4,592	5,144	4,989	5,018	6,402	36.01
GRAND TOTAL	12,087	13,645	14,349	15,333	15,802	17,514	18,701	20,037	20,171	40.07

Source: Annual Reports, Department of Public Health, 1960 - 1968, Alberta.

> The increase in paid staff of general hospitals exceeded the increase in volume of days of care which general hospitals provided to in-patients. In 1968 there were 14.18 paid hours of hospital staff for every day of in-patient care for adults and children. This is an increase of .36 hours over the 1967 ratio. Departmentally, the increases took place in the staffs of nursing units (.14 hours per patient day), laboratories (.04 hours), radiology departments (.06 hours), physiotherapy departments (.03 hours), medical records (.03 hours), nursing education (.03 hours), and other special services (.03 hours). These increases may reflect a greater availability of trained personnel as well as an increase in the utilization of special diagnostic and therapeutic services for both in-patients and out-patients.[32]

LABOUR COSTS

It has been noted that the hospital labour force has increased significantly in the last 10 years. Concomitant with this increase has been a general rise in the cost of hospitalization--the largest portion of which can be attributed to wages and salaries.

Reference to Table XI indicates that the hospital industry experienced the highest proportional increases in salaries and wages compared to nine other industries over an eight year period--155.1 per cent increase.

Historically, the production of patient care services in hospitals was largely labour intensive. Today, many of the hospitals' processes are

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[32] Annual Report, Department of Public Health, Alberta, 1968.

TABLE XI

ESTIMATE OF SALARIES AND WAGES BY SELECTED INDUSTRY, CANADA, 1961 - 1968

Selected Industry	1961	1962	1963	1964	1965	1966	1967	1968	% change 1961-68
	millions of dollars								percent
Manufacturing	5,759	6,173	6,594	7,206	7,981	8,898	9,517	10,167	76.5
Service*	2,906	3,220	3,483	3,914	4,506	5,200	6,066	6,914	137.9
Trade	2,721	2,920	3,130	3,364	3,662	4,037	4,402	4,847	78.1
Transportation, storage, communication and other utilities	2,465	2.543	2,691	2,879	3,139	3,402	3,830	4,106	66.6
Construction	1,475	1,595	1,676	1,870	2,262	2,660	2,771	2,855	93.6
Finance, insurance and Real Estate	975	1,064	1,156	1,290	1,447	1,594	1,827	2,051	110.4
Public, general and allied special hospitals	452	510	564	637	725	840	987	1,153	155.1
Mining	552	581	694	622	697	765	846	919	66.5
Forestry	299	319	326	363	387	423	453	434	45.2
Agriculture, fishing and Trapping	268	275	281	288	314	326	355	375	39.9

*Excluding public, general and allied special hospitals.

Source: Estimate of Labour Income (Catalogue No. 72-005), Employment Section, Labour Division, DBS.

becoming more capital intensive. This fact, though, is not because there has been any dramatic substitution of capital for labour. The hospital has simply added new products such as cardiac monitoring, twelve-channel blood analysers, and X-Ray machines with 90-second mechanical developers, without really eliminating any labour. In effect, technological change has tended to be capital rather than labour augmenting. It is worth noting that most of these new innovations have occurred in the supporting services of the hospital. The appearance of capital substitution for labour in the nursing department has been almost negligible.

The fact that hospitals are a labour intensive industry is important in recognizing that the labour costs have a direct impact on operating costs. Reference to Table XII indicates the wage rates for personnel in Alberta hospitals and the percentage increases over a four year period. These wage increases account for the significant increase in hospital costs noted in Table VIII, on page 29.

UTILIZATION

Admissions per 1,000 population. This factor also exerts an upward pressure on costs because every patient admitted to hospital, utilizes both general and patient services. In 1950, there were an average of 178

TABLE XII

SALARY RATE PER MONTH 1966-1969 FOR
ALBERTA HOSPITAL PERSONNEL

Description	AVERAGE 1966	1967	1968	1969	% change 1969 over 1966
Nursing Services	$	$	$	$	
1. Nurse, Staff - R.N.	387	413	446	503	23.06
2. Nursing Auxiliary - certified	258	278	317	353	26.91
3. Nursing " uncertified	222	240	259	301	26.24
4. Nursing Orderly, Experienced - Male	343	379	394	443	22.57
5. Nursing Orderly, Inexperienced - Male	298	308	321	380	21.58
6. Psychiatric Attendant - Male	448	-	343	384	
7. Psychiatric Aide - Female	-	251	268	293	
Diagnostic and Treatment Services					
8. Laboratory Technician (Medical) - Male	389	404	453	511	23.87
9. Laboratory Technician (Medical) - Female	363	404	432	476	23.73
10. Laboratory Assistant - Male	260	-	403	471	44.79
11. Laboratory Assistant - Female	234	269	293	319	25.89
12. Morgue Attendant	351	383	457	478	26.57
13. Remedial Gymnast, Staff	385	417	467	502	23.30
14. X-Ray Technician, Male	386	422	461	505	23.56
15. X-Ray Technician, Female	344	393	416	470	26.80
Dietary and Housekeeping Services					
16. Cook, Male	375	385	396	456	17.76
17. Cook, Female	270	298	307	363	25.62
18. Assistant Cook, Male	265	278	281	340	25.06
19. Assistant Cook, Female	211	239	363	301	29.90
20. Laundry Operator, Heavy Duties, Male	313	320	345	388	19.33
21. Laundry Operator, Light Duties, Female	216	243	261	307	29.64
22. Maid, Hospital	211	237	254	290	27.29
23. Seamstress	234	256	279	316	25.94

TABLE XII (Continued)

Description	AVERAGE 1966	1967	1968	1969	% change 1969 over 1966
	$	$	$	$	
Maintenance and Service					
24. Carpenter	2.43	2.69	2.78	3.36	27.68
25. Electrician	2.74	3.05	3.21	3.86	29.01
26. Mechanic	2.43	-	-	-	25.69
27. Stationary Engineer, 1st Class	-	-	-	-	
28. Stationary Engineer, 2nd Class	3.28	3.47	3.70	4.32	24.07
29. Stationary Engineer, 3rd Class	2.52	2.65	2.84	3.31	23.88
30. Stationary Engineer, 4th Class	2.20	2.34	2.17	2.76	20.28
31. Stationary Fireman	1.95	2.06	2.23	2.44	20.08
32. Truck Driver, Light and Heavy	2.05	2.14	2.29	2.68	23.50
33. General Labourer	1.66	1.83	1.89	2.03	18.22

Source: Wage Rates, Salaries and Hours of Labour, Canadian Department of Labour, Ottawa, 1966-1969.

admissions per 1,000 population; by 1968 this had been increased to 211--an increase of 15.6 per cent.[33]

Recognition of the safety of receiving medical care in hospitals has been a major factor in the increased demand for hospital facilities. This attitude of patients is closely paralleled by the attitudes of the medical profession which recognizes that only in the modern hospital is it possible to bring together all the skilled personnel and complex equipment required to provide the patients with the necessary services.

An example of the attitude towards the use of hospitals is reflected in the number of operations performed. In 1960, 95,373 operations were recorded in Alberta hospitals. This compares with 133,703 operations in 1968--a 28.1 per cent increase.[34]

Length of Stay. How long patients stay in the hospital is as important as the question of how often they are admitted and the daily cost incurred while being hospitalized. The average length of stay in Alberta hospitals has been decreasing over the years, although the cost per day has been increasing because of the intensity and type of services available.

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[33] Annual Report, Alberta Hospitalization Benefits Plan, 1950 and 1968.

[34] Ibid., 1964 and 1968.

In the early 1930's the average length of stay of a patient with pneumonia was approximately five to six weeks; the cost per patient day was around seven dollars. The total cost for the period of hospitalization would have ranged from $245.00 (5 weeks x 7 days @ $7.00) to $294.00. In 1968, the average length of stay of a patient with pneumonia was 10 days and the average cost per day was $44.00. The total cost would amount to $440.00.[36]

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[35]Annual Report, Alberta Department of Public Health, 1930, p. 18.

[36]Annual Report, Alberta Hospitalization Benefits Plan, 1968, pp. 39-41.

CHAPTER III

EMPLOYER AND EMPLOYEE ORGANIZATIONS IN THE ALBERTA HOSPITAL SYSTEM

A labour relations system is defined as the interaction in the work place of a group of actors.[1] The interaction is governed by the policies and procedures of the law which have as their objective, the attainment of economic justice for the participants.[2] The system usually functions as a power struggle between the main participants as each group of actors pursues its own particular set of goals. The purpose in this chapter is to isolate and describe the main participants in the labour relations system in Alberta hospitals and briefly discuss their organizational structure.

I. ACTORS

There are two distinct groups of actors which shall be classified as the major group and the subsidiary group. The major actors in the Alberta hospital industry are the boards of the various hospitals and their representative

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[1] John Dunlop. Industrial Relations System (New York: Henry Hold and Company, 1958), p. viii.

[2] The major Legislature Acts with which this Chapter is concerned are listed in Appendix I.

association on the one hand, and on the other hand the 20,000 employees who are represented by three main unions and eleven employee associations. The subsidiary actors are comprised of the legislative and administrative bodies set up for facilitating the processes of labour relations.

II. THE MANAGEMENT

As mentioned in Chapter II the hospital system in Alberta is divided among four distinct ownership groups. There are municipal hospital boards and lay ownership hospital boards regulated under the Alberta Hospitals Act. The individual hospital boards in these two groups are given responsibility to own and operate their respective institutions. Their labour-management relationships are governed by the Alberta Labour Act.

The four Provincial Hospitals are administered under the auspices of four boards of management. The boards are given full authority to deal with labour relations problems under the Public Service Act of Alberta and the Crown Agencies Employee Relations Act. The eight Federal Hospitals are similarly regulated under the Federal Public Services Act.

THE ALBERTA HOSPITAL ASSOCIATION

The Alberta Hospital Association was set up under the Alberta Hospital Association Act in 1948 to act as an employer's association. The purpose of the Association as outlined in Section 2 of the Act, is to study,

consider, discuss, accumulate, and distribute information and advice to member hospitals.[3] For the purpose of this study, Section 2, subsection 6 of the Act is given:

> The representation of those Alberta hospitals affiliated with the Association in negotiations with municipal, provincial, and federal bodies.[4]

As provided for in the Act (Section 8), the affairs of the Association are to be administered by a Board of Directors of not less than seven and not more than fifteen members. All members of the Board are to be members or employees of a hospital board. At the present time there are thirteen members on the Board of Directors.[5]

The member hospitals of the Hospital Association are assessed a fee based on the number of beds each hospital has. The monies collected are used to finance the affairs of the Association which include a labour relations department.[6]

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[3]See definitions of "Member Hospitals" in Appendix II.

[4]Alberta, The Alberta Hospital Association Act (Edmonton: Queen's Printer, 1948), Section 2 (6).

[5]Interview with Mr. M. Ross, Executive Director, Alberta Hospital Association, March, 1967.

[6]A discussion of the role of Hospital Associations in labour relations is found in Norman Metzger, "Association Bargaining: The Dilemna of the Organized Hospitals," Hospital Management (April, 1968), pp. 68-76.

III. EMPLOYEE UNIONS AND ASSOCIATIONS

The other main actors in the labour relations system are the employees in Alberta hospitals. These employees may be grouped into two broad categories, one being the unions, the other the paramedical associations. (Table XIII, page 49). The union structure will be considered first.

UNIONS

The Canadian Union of Public Employees (C.U.P.E.)

The Canadian Union of Public Employees, formally known as the National Union of Public Employees, is the second largest Canadian union with over 136,000 members in 70 locals. C.U.P.E. did not formally enter the hospital field in Alberta until six years ago. Since 1964, C.U.P.E. has unionized 29 hospitals in Alberta (Table XIV, page 50).[7]

Membership in C.U.P.E. is restricted to hospital service workers. These employees include orderlies, cooks, housekeepers, maintenance staff, porters, ward aids, and business office staff. A statement found in all C.U.P.E. Union Contracts, states that:

> The Canadian Union of Public Employees is the sole bargaining agent for all hospital employees except for professional employees, nurses and certified nursing aids,

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[7] Information on C.U.P.E. was obtained in an interview with Mr. L. Lancaster, Local C.U.P.E. representative in Edmonton, March, 1970.

TABLE XIII

EMPLOYEE GROUPS IN ALBERTA HOSPITALS

1. Civil Service Association of Alberta (Provincial Hospital Employees)
2. Federal Civil Service Association (Federal Hospital Employees)
3. Canadian Union of Public Employees (C.U.P.E.)
4. Service Employees International Union (S.E.I.U.)
5. Alberta Certified Nursing Aides Association
6. Alberta Association of Registered Nurses
7. Alberta Registered Dietitians Association
8. Alberta Society of Dietary Technicians
9. Combined Laboratory and X-ray Technicians
10. Canadian Society of Hospital Pharmacists
11. Canadian Society of Inhalation Therapy Technicians
12. Canadian Society of Radiology Technicians
13. Alberta Association of Medical Record Librarians
14. Alberta Society of Occupational Therapists
15. Association of Chartered Physiotherapists of Alberta

Source: The Alberta Hospital Association, Interview, March, 1969.

TABLE XIV

HOSPITALS UNIONIZED BY THE CANADIAN UNION OF PUBLIC EMPLOYEES

	Hospital	Bargaining Position
1.	Athabasca Municipal Hospital	A.H.A. - C.U.P.E.
2.	Crows Nest Pass Municipal Hospital	A.H.A. - C.U.P.E.
3.	Alberta Children's Hospital	A.H.A. - C.U.P.E.
4.	Crossbow Auxiliary Hospital	A.H.A. - C.U.P.E.
5.	St. Mary's Hospital (Camrose)	A.H.A. - C.U.P.E.
6.	Drumheller General Hospital	A.H.A. - C.U.P.E.
7.	St. Joseph's Hospital (Edmonton)	A.H.A. - C.U.P.E.
8.	Norwood Auxiliary Hospital	A.H.A. - C.U.P.E.
9.	Lynwood Auxiliary Hospital	A.H.A. - C.U.P.E.
10.	Good Samaritan Hospital	A.H.A. - C.U.P.E.
11.	Elk Point Municipal Hospital	A.H.A. - C.U.P.E.
12.	St. John's Hospital (Edson)	A.H.A. - C.U.P.E.
13.	Grande Prairie Municipal Hospital	A.H.A. - C.U.P.E.
14.	Grande Prairie Auxiliary Hospital	A.H.A. - C.U.P.E.
15.	Providence Hospital (High Prairie)	A.H.A. - C.U.P.E.
16.	Innisfail Municipal Hospital	A.H.A. - C.U.P.E.
17.	Lethbridge Municipal Hospital	A.H.A. - C.U.P.E.

TABLE XIV (continued)

	Hospital	Bargaining Position
18.	Lethbridge Auxiliary Hospital	A.H.A. - C.U.P.E.
19.	Medicine Hat General Hospital	A.H.A. - C.U.P.E.
20.	MacCharles Auxiliary Hospital	A.H.A. - C.U.P.E.
21.	Peace River Municipal Hospital	A.H.A. - C.U.P.E.
22.	Fairview Auxiliary Hospital	A.H.A. - C.U.P.E.
23.	St. Vincent's Hospital	A.H.A. - C.U.P.E.
24.	Dr. Parsons Auxiliary Hospital	A.H.A. - C.U.P.E.
25.	Red Deer General Hospital	A.H.A. - C.U.P.E.
26.	St. Therese Hospital	A.H.A. - C.U.P.E.
27.	Wetaskiwin Municipal Hospital	A.H.A. - C.U.P.E.
28.	Wetaskiwin Auxiliary Hospital	A.H.A. - C.U.P.E.
29.	Royal Alexandra Hospital	Board - C.U.P.E.
30.	General Hospital (Calgary)	Board - C.U.P.E.
31.	Holy Cross Hospital (Calgary)	Board - C.U.P.E.

Source: Leo Lancaster, C.U.P.E. representative, Edmonton (April, 1970).

graduate and student pharmacists, graduate dietitians, medical record technicians, dietary technicians, X-Ray technicians, laboratory technicians, physio and occupational therapists, inhalation therapists, and social workers.[8]

According to C.U.P.E. officials, there are a number of factors responsible for the growth of unionism in Alberta hospitals.[9]

1. Hospitals have paid lower wages than other industries, and have expected employees to rely on noneconomic rewards. This influenced employees to seek union membership.

2. Personnel procedures and practices particularly job advancement, were weak in hospitals and employees sought ways of changing this.

3. Hospitals in the larger urban centers were pursuaded to unionize as a result of increased union activity on the part of other urban industrial workers.

Service Employees International Union (S.E.I.U.)

The Service Employees International Union, formally called the Building Service Employees Union was chartered in Canada in 1921. Originally, the S.E.I.U. was concerned with only the janitorial staff in office buildings but in the last ten years it has become interested in representing the

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[8]Union Agreement (1969-1970) between the Royal Alexandra Hospital (Edmonton) and the Canadian Union of Public Employees Local No. 47.

[9]Interview--Mr. L. Lancaster, op. cit., March, 1970.

service employees in hospitals. As a consequence, it was decided in 1969 to drop the word "Building" from its title.

According to S.E.I.U. officials, the union is the bargaining agent for six hospitals in Alberta.[10] The union represents employees occupying positions designated as:

> Admitting clerk, office clerical staff, cooks, housekeeping service workers, laundry and union staff, and hospital aids.[11]

Table XV on page 54 indicates the number of Alberta Hospitals unionized by the S.E.I.U. The major reasons given by the secretary of the Service Employees International Union for unionizing these hospitals was the fact that the employees, as individuals, were in a weak bargaining position and required the expertise of a strong union organization in negotiating wages and working conditions.

The Civil Service Association of Alberta

The Civil Service Association of Alberta was incorporated in March, 1919. By the declaration of incorporation, the Association was legally acknowledged as a society whose purposes would be:

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[10] Information obtained in an interview with the Secretary of the S.E.I.U. in Edmonton, March 1970.

[11] Definition of membership is from the Agreement between the Misericordia Hospital (Edmonton) and the Service Employees International Union, (1967-1970).

TABLE XV

HOSPITALS UNIONIZED BY THE SERVICE EMPLOYEES INTERNATIONAL UNION

Hospital	Bargaining Position
General Hospital (Edmonton)	Board - S.E.I.U.
Misericordia (Edmonton)	Board - S.E.I. U.
Fort Saskatchewan Hospital	A.H.A. - S.E.I.U.
Wainwright Auxiliary Hospital	A.H.A. - S.E.I.U.
Wainwright General Hospital	A.H.A. - S.E.I.U.
Westlock Hospital	A.H.A. - S.E.I.U.

Source: Interview with Secretariat of the S.E.I.U. in Edmonton.

(a) to develop the education, training, and skill of the members of the Association.

(b) to promote and to safeguard harmony between the government and the members of the Association.

(c) to unite the members of the Association for their mutual improvement.

(d) to enter into and attempt to conclude satisfactorily agreements between the Association and the Government or any board or agency of the government. [12]

The Civil Service Association of Alberta represents employees of the four provincial hospitals in collective bargaining sessions. Membership in the Association is based on Section 2 of the Crown Agencies Employee Relations Act which states that:

(c) "Employees" means persons employed by an employer other than (i) persons who, in the opinion of the Minister exercise a policy-making function in matters relating to personnel administration or who make significant decisions respecting the treatment of employees, or (ii) persons who are members of a professional association who are excluded by the Minister at the request of a majority of the persons in the group. [13]

The membership of the Association is divided among 49 branches within the Province of Alberta. Each branch has a constitution and elects an executive who manage the business of the branch. In addition, the branch elects delegates annually to attend the annual Provincial Convention of the Association

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[12]Alberta, Constitution and B ylaws of the Civil Service Association of Alberta, Section 1, page 2.

[13]Alberta, Crown Agencies Employee Relations Act (Edmonton: Queen's Printer, 1968), Section 2.

at which time a Provincial executive is elected. The day-to-day affairs of the Association are undertaken by a Secretariat in Edmonton.[14]

EMPLOYEE ASSOCIATIONS

The emphasis on unions, because they are the common forms of employee representation, has tended to obscure the wide variety of other occupational associations which represent the interests of hospital personnel. In the last ten years the hospital industry has witnessed the proliferation of numerous professional and paraprofessional associations covering almost every health occupation from interns and hospital administrators through medical record librarians, inhalation therapists, and radiological technicians. Among other things, these occupational associations may function to provide a means for:

> (1.) social fraternization, (2.) occupational identification, (3.) raising the occupation's status in the hospital and the community, (4.) furthering professional objectives by self-regulation and restriction of entry, and (5.) advancing the economic interests of members.[15]

The following pages outline the organization of a number of occupational

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[14]This information was obtained in an interview with the Secretariat of the Civil Service Association (Edmonton), March, 1970.

[15]For a more detailed description of the purposes of hospital occupational associations, see David Kockery and George Strauss, "Non-Profit Hospitals and the Union," Buffalo Law Review, VII (Winter, 1960), pp. 255-282.

associations that have developed in Alberta hospitals. A list of the associations is set out in Table XIII, page 49.

The Canadian Society of Radiological Technicians, Alberta Division

The Alberta Division of the Canadian Society of Radiological Technicians was formed in July, 1947. The initial purpose of the society was to exchange information on the responsibilities of X-Ray technicians.[16] The objectives of the Society have extended far beyond the original purpose. As defined in the Radiological Technicians Act, the Society is responsible for the registration of X-Ray technicians, organization of postgraduate refresher courses, and promoting the welfare of technicians in all matters in the fields of education and salaries.[17]

Alberta Registered Dietitians Association

The Alberta Registered Dietitians Association was incorporated on May 9, 1959. The Association was formed primarily to act as a registering body in order to ensure that the dietitians in hospitals are qualified.[18] In addition, the Association represents registered dietitians in all matters relating

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[16]Information obtained in a letter from P.R. Schmidt, President of the Alberta Division of the Canadian Society of Radiological Technicians, July, 1970.

[17]Alberta. The Radiological Technicians Act (Edmonton: Queen's Printer, 1963), Section 4.

[18]Information obtained in a letter from Mrs. Jordinson, The Alberta Registered Dietitians Association, August, 1970.

to the establishment of educational qualifications.[19]

The Alberta Society of Dietary Technicians

The Alberta Society of Dietary Technicians was intially formed on July 26, 1968. It was registered under the Alberta Societies Act on November 22, 1968.[20]

The underlying reasons for its formation were to: (1) increase public knowledge of what a dietary technician is capable of doing, (2) provide technicians with information on new trends and techniques in the dietary field; (3) act as a registering body, and (4) represent technicians in salary negotiations.

The Alberta Association of Medical Record Librarians

The Alberta Association of Medical Record Librarians was formed in May, 1960. The purposes of the Association were to: (1) elevate the standard of the clinical records in hospitals; (2) provide means for acquiring and disseminating among members facts and opinions useful to them; (3) provide means for exchanging ideas among members; (4) establish and maintain a roster of members; and (5) represent members in salary negotiations.[21]

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[19]Alberta. The Registered Dietitians Association Act (Edmonton: Queen's Printer, 1959), Section 10.

[20]Information obtained in a letter from Mrs. Connelly, Alberta Society of Dietary Technicians, August, 1970.

[21]Information obtained in a letter from Mrs. Wilson, Alberta Association of Medical Record Librarians, August, 1970.

The Alberta Association of Registered Nurses

The graduate nurses of Alberta organized and were granted an Act of Incorporation in 1916. This Act entitled the nurses of Alberta to maintain and carry out functions as a collective group but did not include collective bargaining rights.[22] The Act was amended in 1966 in order that the Association could act as a bargaining agent for nurses in addition to its other responsibilities of a registering body.[23]

The Canadian Society of Inhalation Therapy Technicians

The most recent example of a paramedical field that has been introduced into the hospitals is the inhalation therapy service. As this paramedical specialty grew, the members felt it was necessary to form a formal organization. As a consequence, the Canadian Society of Inhalation Therapy Technicians was founded and received its letters patent in December, 1964. The Alberta Branch of the Society was formed in 1968.

The reasons given for the organization of the Society were to: (1) ensure all inhalation therapy technicians are qualified; (2) act as a registering body; (3) provide continuing education programs; and (4) to represent inhalation therapists in salary negotiations.[24]

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[22]Interview with Miss Todd, Alberta Association of Registered Nurses, March, 1970.

[23]Alberta. The Registered Nurses Act (Edmonton: Queen's Printer, 1955), Section 3 (3).

[24]Interview with Mr. Baril, Alberta Branch of the Canadian Society of Inhalation Therapy Technicians, March, 1970.

III. THE SUBSIDIARY ACTORS

The foregoing has been a description of the major actors in the labour relations system in the Alberta Hospital Industry. There is, however, another group of actors which are subsidiary to the main parties. This group is designed to regulate and mediate the relationships between the unions and management in their collective negotiations. The subsidiary actors consist of the Alberta Industrial Relations Board and the various conciliation services of the Alberta Department of Labour.

The Alberta Industrial Relations Board

In a discussion of a labour relations system, the Alberta Industrial Relations Board is an important participant because of the key role it plays in deciding who are "employers" and "employees." In addition, it decides whether or not an employee's association is a group appropriate for bargaining, and whether an individual employee is a member in good standing in employee's association or union. The Board's activities and decisions have far reaching consequences upon the structure of trade unionism within a particular industry.[25]

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[25]According to Section 6 of the Alberta Labour Act, the Board of Industrial Relations shall consist of not more than five members. This Board is chaired by the Deputy Minister of Labour and has two members named by the Trades-Labour Council and two by the Canadian Manufacturing Association. The duties of the Alberta Industrial Relations Board are described in detail in The Alberta Labour Act (Edmonton: Queen's Printer, 1968), Section 6 - 10.

The Alberta Industrial Relations Board's practice is to recognize, as eligible for certification, as a bargaining unit, only those crafts that are well established occupations with a tradition of collective bargaining in the province. The Board is not primarily concerned with protecting or advancing the cause of either craft or industrial unions as such, but only in ensuring that a group of employees is allowed bargaining rights. While other provinces have permitted craft development, the Alberta Act merely states that a unit may be a craft or industrial type, recognizing that either one type or the other may be more appropriate depending upon the type of industry. The effect of the Board on unions and associations in the hospital industry will be described in Chapter IV.

The Conciliation Services

The conciliation services as set out in the Alberta Labour Act are designed to facilitate negotiations between employees and employers.[26] The significance of these services are felt only after the initial stages of the collective bargaining process have proven fruitless. As in the case of the Industrial Relations Board, the function of this subsidiary actor in the labour relations system in Alberta hospitals will be discussed in the following chapter.

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[26]The conciliation services are outlined in The Alberta Labour Act, op. cit., Sections 84-92.

CHAPTER IV

COLLECTIVE BARGAINING IN THE ALBERTA HOSPITAL SYSTEM

One of the main tasks of a labour relations system is to develop the means whereby terms and conditions of employment are determined. The major procedure by which terms and conditions of employment are settled for employees in Canadian industries is collective bargaining.

I. INTRODUCTION TO COLLECTIVE BARGAINING

In 1867, when the B.N.A. Act was passed, the labour movement in Canada was in its infancy and the Canadian constitution therefore, failed to allocate the responsibilities for labour relations. As a result, the courts were relied upon to distribute this responsibility. The Federal Government first assumed responsibility for collective bargaining in Canada by passing the Industrial Disputes and Investigation Act (I.D.I.) in 1907. After 1925, the provincial governments either passed modified I.D.I. Acts or agreed to extend coverage of the I.D.I. Act to their respective provincial industries. By 1935 it became evident that the provinces had taken charge of their own labour relations problems and had accordingly established their own policies.

With the passage of the Industrial Standards Act (now the Alberta Labour Act) in Alberta in 1935, the practice of collective bargaining was

defined for the Province. Since that time, the courts have upheld, as a guarantee to employees, the right to organize for the purpose of bargaining collectively with their employers. Business, with few exceptions, has come to recognize that this practice is here to stay and has been adjusting its organizational and operational structure to allow for it.

There are two particularly important sections of the Alberta Labour Act which affect collective bargaining. The first is Section 57, which gives employees the right to organize and to select representatives for the purpose of collective bargaining. The other is Section 72, which establishes as an unfair labour practice company interference with this right. One of the eight unfair labour practices included in Section 72, specifically states that it is an offense for an employer to refuse to bargain with the representatives of his employees.[1]

The basic pattern of collective bargaining is thus set forth by law and both the employers and the employees must act accordingly. While appearing to be simple on the surface, collective bargaining is actually a complicated and difficult process which must be thoroughly understood in order to ensure the proper end results. In addition, it is not an end in itself, but merely one step in the establishment of sound employee-employer relationships under conditions of unionization.

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[1] The Alberta Labour Act, op. cit., Sections 57, 72.

For purposes of this paper the term "collective bargaining" shall be defined as the process by which representatives of a company and its employees discuss and negotiate the various phases of their relationship with a view to arriving at a mutually acceptable labour agreement. Collective bargaining shall also include the following characteristics:[2]

1. An employer (or his representative) must recognize a certified bargaining unit. (The certified bargaining unit may be either an employees association or a union).
2. Both parties are legally obligated to bargain collectively.
3. Almost any topic must be discussed in a negotiating session if made an issue.
4. When both parties agree on the points being discussed agreement must be put in writing.
5. Bargaining meetings must be held at reasonable times convenient to both parties.

II. BARGAINING STRUCTURE IN THE ALBERTA HOSPITAL INDUSTRY

GENERAL

The "structure of collective bargaining" is understood to mean the way in which bargaining is practiced including: (1) who takes part, (2) where

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[2]Wilson C. Randle, Collective Bargaining Principles and Practices (Cambridge Mass.: The Riverside Press, 1951), p. 83.

the decisions are made, (3) what employers and employees are covered, and (4) the processes of negotiation. The structure necessarily rests upon the bargaining unit and upon the nature of the industry.

The Bargaining Units in Alberta Hospitals

The negotiation of a collective agreement takes place between the employer and representatives of an appropriate unit of employees. The definition of such employee units is determined by the Alberta Board of Industrial Relations as the subsidiary actor in the labour relations system. The Board ensures that the employee unit reflects a group of employees with common work functions.[3]

There are two types of bargaining units in Alberta hospitals. The first is designed as the certified bargaining unit and the second as the voluntary bargaining unit.

A certified bargaining unit is a group of employees working in a hospital with similar job descriptions who have been granted certification by the Alberta Board of Industrial Relations. The following groups of employees have been certified by the board:

1. Thirty-one locals of the Canadian Union of Public Employees (Table XIV).
2. Six locals of the Building Service Employees Union (Table XV).

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[3]The procedure for defining a group of employees as a bargaining unit is found in The Alberta Labour Act, op. cit., Sections 56-71.

3. Twenty-five locals of the Alberta Association of Registered Nurses.

A voluntary bargaining unit is a little more difficult to define. In the case of the voluntary bargaining unit the recognition of a group of employees, as a unit appropriate for bargaining, is made by the employer rather than the Industrial Relations Board. This procedure of voluntary recognition is a unique aspect of the labour relations system in Alberta hospitals.

This voluntary recognition agreement of the Alberta Hospital Association makes provision for the following procedures:

1. Formal recognition of each paramedical association as a bargaining agent for its respective members.
2. Outlines the procedures to be followed in conducting negotiations.[4]
3. A binding of each party to accept the results of the final negotiated labour agreement.
4. The procedure for terminating the agreement.[5]

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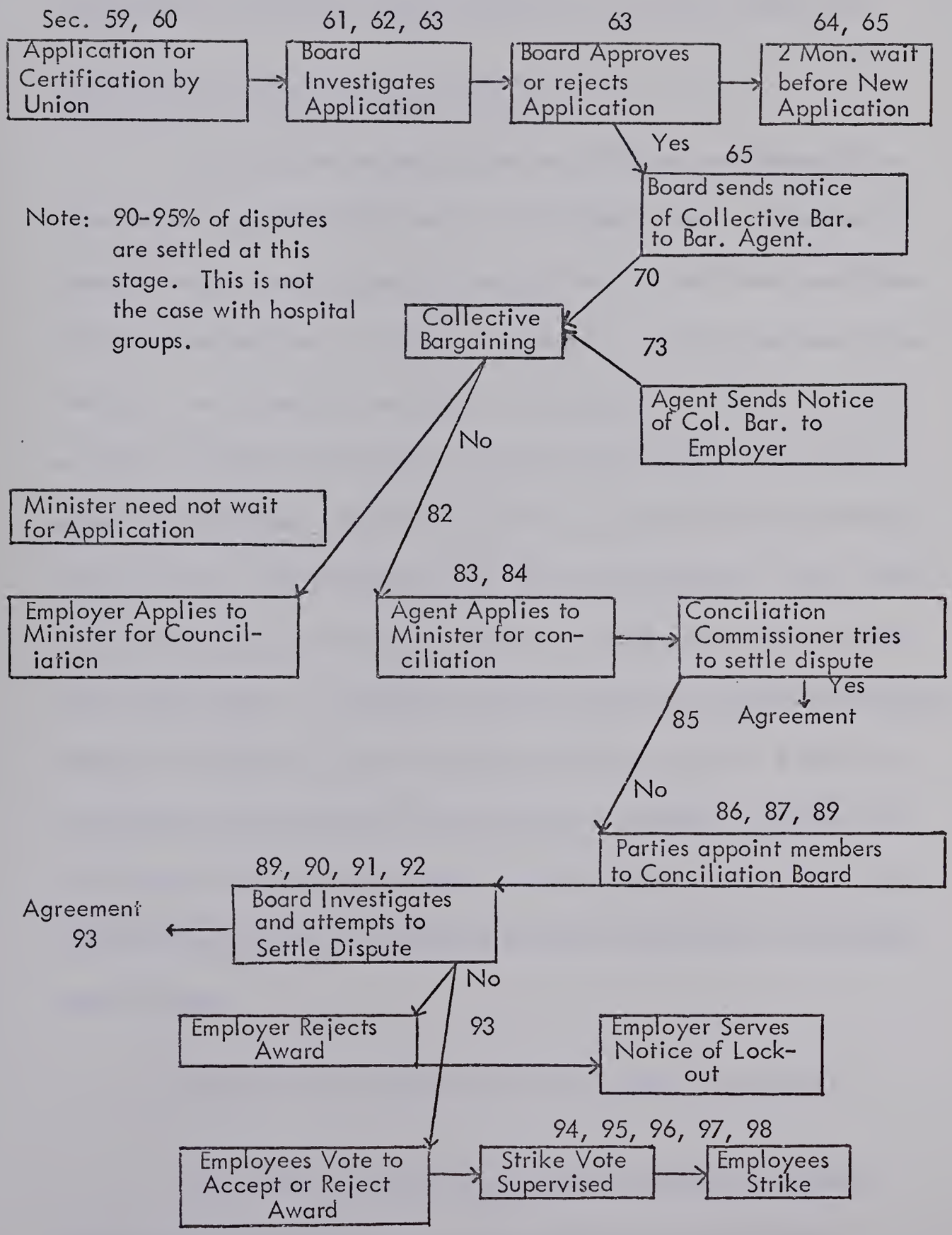
[4]Under point number 2 above--it is the intent of the agreement to make use of the collective bargaining principles and procedures laid down in the Alberta Labour Act (see Figure 4, page 67). While utilization of conciliation services under the Act is a definite objective, this will not be realized until amendments to the Act have been approved by the provincial legislature. Present legislation does not cover negotiations between Associations which are not representing groups certified as bargaining units. If the necessary legislation is passed by the government, both parties will be able to use the services of Conciliation Commissioners and Conciliation Boards.

[5]E. H. Knight. "Alberta's province-wide bargaining program now the most extensive underway in Canada," Hospital Administration in Canada (March, 1968), p. 53.

FIGURE IV

ALBERTA LABOUR ACT



Source: The Alberta Labour Act, Part V, Sections 55-108.

The paramedical associations that have been accorded voluntary recognition by the Alberta Hospital Association are listed in Table XVI.

The Nature of the Alberta Hospital Industry

The collective bargaining structure of the hospital industry is in large measure a product of the nature of the industry itself. The industry is characterized by intensive and detailed government regulation of every facet of the hospital operation, including provisions for ownership, approval of the location of every hospital, the types of services each hospital can provide, as well as regulation of the labour management relationships. The extent of government regulations reflects the facts that: (1) Hospitals are providing an essential service; (2) Providing around-the-clock-operation, 7 days a week; (3) Hospitals have to rely on government for over 80 per cent of its capital and operating costs; (4) Hospitals experience constant and rapid technological change which affects the type of employees that are required. Regulations are required in order to ensure every employee is qualified. Coupled with the discussion of the bargaining units, the characteristics listed above have influenced the processes of negotiating collective agreements in the Alberta hospital industry.

PROCESSES OF NEGOTIATION IN ALBERTA HOSPITALS

The processes of negotiating collective agreements in Alberta hospitals do not lend themselves to easy classification and description.

TABLE XVI

PARAMEDICAL ASSOCIATIONS CERTIFIED BY THE ALBERTA HOSPITAL ASSOCIATIONS

The Para-medical associations
1. Alberta Certified Nursing Aides
2. Alberta Registered Dietitians Association
3. Alberta Society of Dietary Technicians
4. Combined Laboratory and X-Ray Technicians
5. Canadian Society of Hospital Pharamcists
6. Canadian Society of Inhalation Therapists
7. Canadian Society of Radiology Technicians
8. Alberta Association of Medical Record Librarians
9. Alberta Society of Occupational Therapists
10. Association of Chartered Physiotherapists of Alberta

Collective bargaining in the industry reflects complex inter-relations that have created a network of agreements applicable to almost every hospital. In order to describe the processes of collective bargaining that have developed the classification system outlined in Table XVII has been utilized.

The Alberta Labour Act

Prior to 1966 negotiations between municipal and voluntary hospitals in Alberta and between the Canadian Union of Public Employees and the Service Employees International Union were undertaken on a local hospital basis. The local bargaining unit would serve notice to the hospital board that it wished to commence bargaining for a new labour agreement. The procedure for bargaining followed the outline of the Alberta Labour Act illustrated by Figure 4 and usually ended at the first stage; that is the collective bargaining step.

In 1966 the Alberta Hospital Association held a meeting in Red Deer at which time the pros and cons of regional bargaining were discussed. The initiative for this discussion had come as a result of an event that occurred in 1965. In 1965, officials of the Hospital Association and the Canadian Union of Public Employees had travelled up to Edson to provide assistance to the hospital in their bargaining. It was decided--since A.H.A. and C.U.P.E. officials could travel together to a hospital then proceed to negotiate across the table--why not eliminate the travelling and undertake bargaining centrally for a number of hospitals. As a consequence, a pilot project was undertaken

TABLE XVII

BARGAINING PROCESSES UTILIZED BY EMPLOYEE ORGANIZATIONS IN ALBERTA HOSPITALS

	Bargaining Process	Employee Organizations Using the Process
1.	Alberta Labour Act - defines the mechanisms for bargaining for certified bargaining units.	Unions - C.U.P.E. - S.E.I.U. Alberta Association of Registered Nurses
2.	Crown Agencies Employee Relations Act - defines the mechanisms for bargaining by provincial employees	Civil Service Association of Alberta
3.	Alberta Hospital Association's Recognition Agreement - defines the bargaining process for groups who have not been certified under the Alberta Labor Act	Employee Associations

to negotiate a master contract for five hospitals.[6]

The negotiations in 1966 of the master contract worked so well that in 1967 the process was extended. There are now 29 hospitals in Alberta operating under a master agreement negotiated by the Alberta Hospital Association and the Canadian Union of Public Employees. The 29 hospitals involved in this contract are listed in Table XIV.

The remaining hospitals unionized by the Canadian Union of Public Employees negotiate individually with their respective hospital boards. To date, there has been little trouble negotiating a collective agreement although a number of contracts have had to be settled at the conciliation stage. Recourse to Section 99 of the Alberta Labour Act which prohibits the use of the strike by employees of essential services, has not been used to date.[7]

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[6]The five hospitals were: Athabasca, St. Joseph's (Edmonton), St. John's (Edson), Peace River General and Auxiliary hospitals, and Wetaskiwan General and Auxiliary hospitals.

[7]The Alberta Labour Act, R.S.A. 1955, c, 167 (as amended) provides for the settlement of public interest disputes. Section 99 provides:

> (1) Where at any time in the opinion of the Lieutenant-Governor-in-Council, a state of emergency exists in the Province in such circumstances that life or property would be in serious jeopardy by reason of:
>
> (a) Any breakdown or stoppage or impending breakdown or stoppage of any system, plant or equipment for furnishing or supplying water, heat, electricity or gas to the public or any part of the public, or
>
> (b) A stoppage or impending stoppage of hospital services in any area of the province, if the state of emergency arises from a labour dispute, the Lieutenant-Governor-in-Council may by proclamation declare that from and after a date fixed in the proclamation, all further action and procedures in the dispute are to be replaced by the emergency procedures under this section.

The Service Employees International Union, utilizing the Alberta Labour Act, negotiates a master contract with the Alberta Hospital Association for four hospitals (See Table XV). The remaining two hospitals unionized by the S.E.I.U. negotiate individually with their respective hospital boards.[8]

The Crown Agencies Employee Relations Act

Until recent years, the prevailing opinion in Canada with respect to government employees was that, "La Reine ne negocie pas," (the Queen does not bargain or there is no bargaining with the Crown).[9] In Alberta in 1968, The Public Service Act and the Crown Agencies Employees Relations Act were passed outlining the methods whereby employees working in provincial institutions could bargain collectively for wages and working conditions. The figure on the following page outlines the process of negotiations that occur between the Civil Service Association (C.S.A.) and the boards (employers) of the four provincial hospitals.

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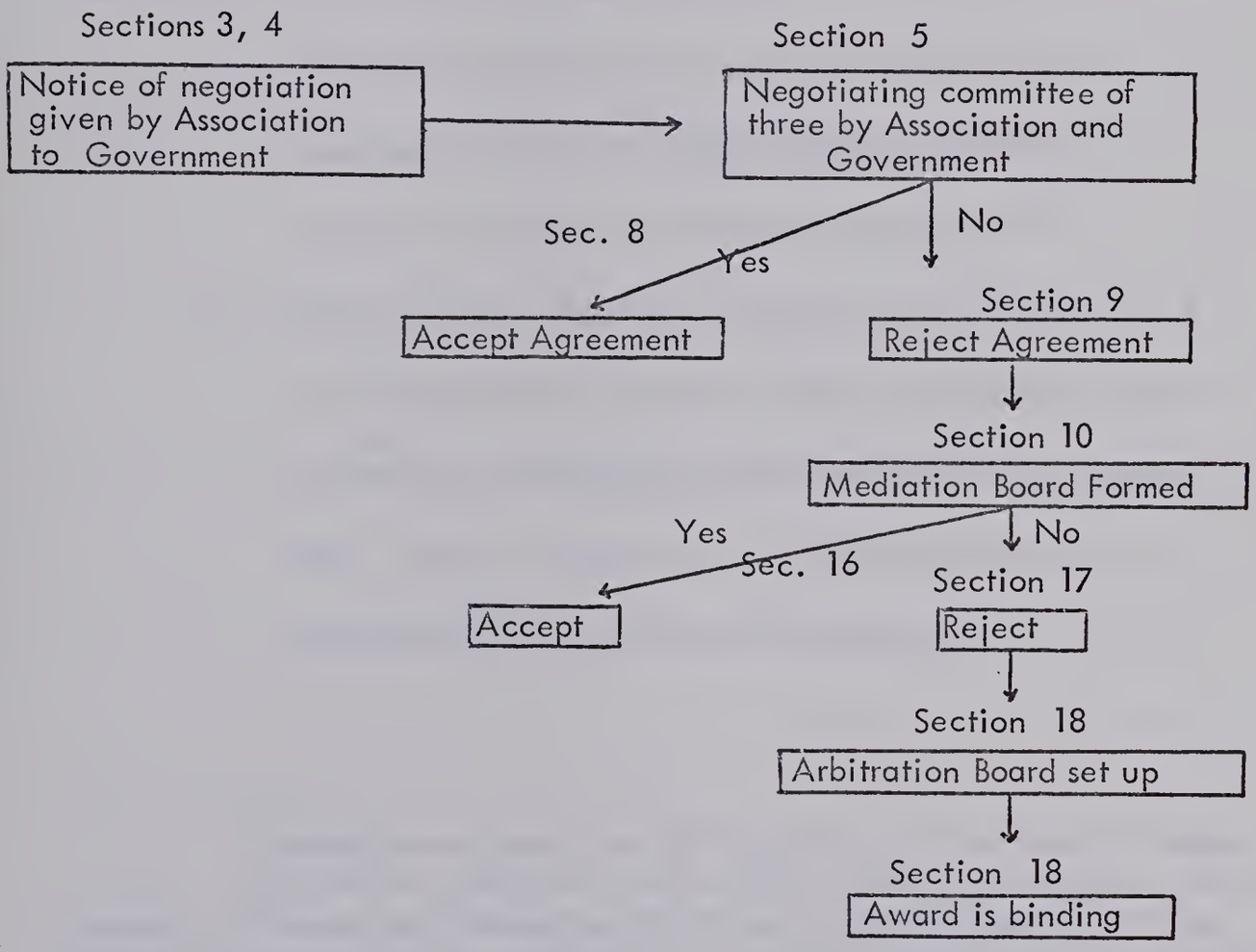
[8]According to S.E.I.U. officials the master contract negotiated by S.E.I.U. and the A.H.A. has been settled before the C.U.P.E.--A.H.A. contract. As a result, the S.E.I.U. contract has resulted in a lower pay range. In 1969, S.E.I.U. settled for a bare rate of $1.70 whereas C.U.P.E. obtained a $1.75 rate. It is hoped by S.E.I.U. officials that in 1971, C.U.P.E. and S.E.I.U. can get together and establish mutually acceptable goals for negotiating with the Alberta Hospital Association.

[9]Kenneth O. Warner. Public Management of the Bargaining Table (Chicago: Public Personnel Association, 1967), p. 35.

FIGURE V

CROWN AGENCIES EMPLOYEE RELATIONS ACT



Refer: Crown Agencies Employee Relations Act (1968), Sections 3 - 18.

For the purpose of negotiations, only employees described in Chapter III under the Civil Service Association shall be considered as the bargaining unit for any one of the provincial hospitals.[10] The method of negotiations is not felt to be too satisfactory according to the Civil Service Association. The reasons for this are two-fold:

1. The Provincial Government does not consider itself a trend setter in terms of wages so binding arbitration results in a wage not satisfactory to employees.[11]
2. The negotiating committee structure utilized by the C.S.A. is cumbersome and in order to ratify an agreement, it has to resort to a complicated procedure to get to the membership. This is to change with the drafting of a new constitution for the Civil Service Association.[12]

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[10]Employees excluded from the bargaining unit include all nurses, C.N.A.'s, Pharmacists, Laboratory Technologists, X-Ray Technicians, Physiotherapists, Occupational Therapists, Dietitians, Medical Record Librarians, Medical Record Technicians and Inhalation Therapy Technicians. These groups have their own associations which bargain for them. The processes whereby these groups bargain will be detailed later.

[11]This was exemplified in a negotiation in January, 1970 where the board and the employees of the W. W. Cross Hospital reached what they felt was a mutually acceptable agreement. The Government decided it would not recognize the settlement as the wage package was above the 6 per cent guideline.

[12]Information obtained from the Civil Service Association of Alberta, March, 1970.

Alberta Hospital Association's Recognition Agreement

In the fall of 1964, the Alberta Hospital Association convened an institute on labour relations.[13] This step came as a result of two factors: (1) An increasing demand for higher wages by the Alberta Association of Registered Nurses,[14] and (2) demands being made by trade unions and employee associations in organizing hospital employees.[15] Attendance at this institute surpassed all expectations, making it clear to the Association that many hospitals were unsure of their labour relationships with employees and that they required assistance.

As a result of these two problems, the Alberta Hospital Association set up a committee on Personnel Relations to be responsible for organizing and directing activities which included: (1) Overseeing and directing all collective bargaining undertaken by the Association; (2) Recommending salaries and personnel policies; and (3) exploring ways to improve the Association's services to its members in the field of labor relations.

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[13]Prior to 1964, the Alberta Hospital Association did not involve itself in any formal salary negotiations. It did meet annually with the Alberta Association of Registered Nurses and drew up suggested salary levels but it was left to the individual hospital boards and their nurses to establish a collective agreement. The unionized employees in Alberta hospitals bargained individually with their hospital boards as did the employee associations.

[14]The development of bargaining by the Alberta Association of Registered Nurses is in Appendix III.

[15]E. H. Knight, op. cit., p. 52

After some discussion with the paramedical associations, it became evident to the Personnel Committee that some mechanism to ensure successful bargaining would have to be developed. Since all the employee groups in Alberta municipal and voluntary hospitals, with the exception of the C.U.P.E. and S.E.I.U. locals, could not certify under the Alberta Labour Act, a recognition agreement procedure was drawn up.

The recognition agreement (outlined in Figure 6) sets out the collective bargaining process whereby the Alberta Hospital Association, acting on behalf of hospital boards in Alberta, bargains with the paramedical associations. According to the Agreement a salary committee appointed by the respective paramedical associations meets with the Alberta Hospital Association. Once an agreement is reached, the parties recommend the agreement to their respective memberships. To date, this procedure has worked quite well.[16]

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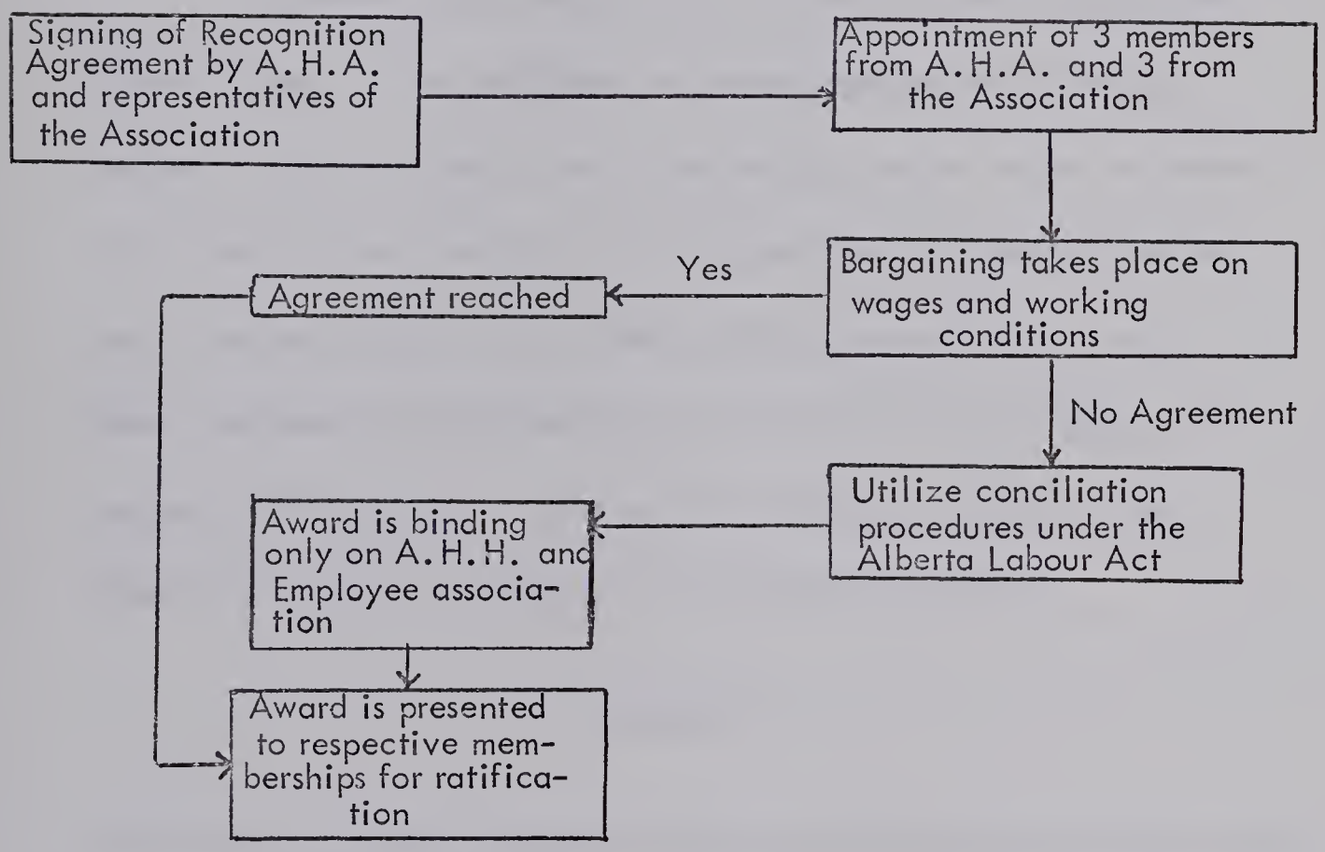
[16]See Appendix IV for discussions of five employee associations and the Recognition Agreement.

FIGURE VI

ALBERTA HOSPITAL ASSOCIATION'S
RECOGNITION AGREEMENT



Source: Taken from the recognition agreement of the Alberta Hospital Association.

CHAPTER V

SUMMARY AND CONCLUDING OBSERVATIONS

The effectiveness and efficiency of any industrial organization depends largely on the collaborative relationships that exist among its members. This is decidedly true in the hospital industry where the nature of the work requires team effort. The cooperative arrangements among the various participants in the Alberta hospital industry that relate to labour management relationships have been the focus of this study. The purpose of this chapter is to summarize the findings of the preceding chapters and to discuss a number of concluding observations.

I. SUMMARY

The center of attention throughout the study has been to describe the various arrangements under which the hospital labour force is organized in Alberta. The study began with a factual description of the labour force, and to the extent possible, it presented statistics on the numbers of employees that were unionized. Unfortunately, the present methods of collecting and reporting labour force statistics make it impossible to identify the exact number of hospital employees that are unionized. Given this provision, it appears

that in 1968, approximately 5.3 per cent of the total labour force in Alberta was employed in the hospital field. This was a 40 per cent increase over 1961. In absolute numbers, this means that slightly over 20,000 people were working in Alberta hospitals during this period.

In order to provide a basis for discussing labour management relations at the local hospital level, the study initially identified the structure under which the Alberta hospital industry was organized. This involved setting out the various areas of responsibility of the Federal and Provincial Governments, both in the financial and the administrative areas.

Under the B.N.A. Act, the major responsibilities for health care were defined to be with the provincial governments. However, since 1957, the Federal Government, under the Hospital Insurance and Diagnostic Services Act agreed to share in the costs of active treatment and chronic cases in approved hospitals. This cost-sharing arrangement has meant that a significant share of hospital cost (40.5 per cent in 1969 for Alberta) has been met by the Government in Ottawa.

Notwithstanding the substantial Federal contribution, the Provincial Government is still committed to heavy expenditures for hospital care in Alberta. In order to adequately administer its responsibility, the Alberta Department of Health assumed the authority to approve and maintain adequate standards of hospital care in the Province. This authority has meant that all the various classes of hospitals are under close scrutiny by the Department. In fact, it was found during the course of the study, that local hospital boards

had very little financial freedom outside of the budgets that are set and approved by the Health Department.

Although the major financial responsibilities for hospital services rests with the Provincial Government, the actual ownership is assumed by a number of groups.

These various arrangements, which are detailed in Chapter II, have resulted in a number of consequences for labour management relationships. Firstly, the Provincially owned hospitals are staffed by employees who come under the Crown Agencies Employee Relations Act, administered by the Provincial Government. As a result, unless otherwise excluded, the employees are required to be members of the Alberta Civil Service Association and must utilize the Association in collective bargaining sessions with their respective hospital boards.

On the other hand, there are 112 Municipal or Voluntary hospitals whose service employees are either not represented by any union or are unionized by the Canadian Union of Public Employees or the Building Service Employees Union. This means that for service employees in Alberta Hospitals, there are four different arrangements for organization. More specifically, there is no formal union structure in 75 Alberta hospitals. The Canadian Union of Public Employees operates in 31 hospitals; the Building Service Employees Union, 6 hospitals; and the Alberta Civil Service Association in four Provincial hospitals. Besides the unions listed above, this study has described the eleven paramedical associations which have organized hospital

personnel in Alberta.

This study concluded by describing the processes of labour management bargaining in Alberta hospitals. It was difficult to do, as the present system does not lend itself to easy classification. Actual collective bargaining in the industry reflects complex inter-relations that have created a network of agreements applicable to almost every hospital.

II. CONCLUDING OBSERVATIONS

On the basis of the description of the labour management relationships in Alberta hospitals, the first concluding observation deals with the trade union structure. The Trade Union structures found in Alberta hospitals may be considered under two separate points although both are ultimately related. The first has to do with the categories of wage-earners recruited by unions; the occupational groups forming its ranks, and the procedures for certifying these groups. The second aspect is more specifically concerned with the locations of the unions and the various collective bargaining procedures which are used to resolve the employees' demands.

With reference to the first aspect, one may say that the prevailing type of organized labour in Canada is industrial unionism, i.e., unions recruiting all members to its ranks in a single industry. However, in Alberta hospitals, two main types of union structure have evolved--namely--the industrial type such as the Canadian Union of Public Employees and the craft type represented by the paramedical associations.

This coexistence of different types of union organization has resulted in a complex labour relations system wherein a single hospital board may have to deal with 12 different employee groups during the course of collective bargaining. Each group placing demands on the hospital which may bear no relationship to the demands of the other groups. The end result is that hospital management spends a considerable amount of its time negotiating and administering numerous collective agreements.

It was argued in the McRuer Report on Civil Rights in Ontario (1968), that the granting of self-government to an occupation is a delegation of legislative and judicial functions and can only be justified as a safe-guard to the public interest. The power is not conferred to give or reinforce a professional or occupational status. The Ontario Commission on the Health Acts (1959) went on to recommend that all paramedical groups should be regulated under the auspices of one health disciplines board. These facts on employee groups led the author to conclude that the paramedical associations in Alberta should be amalgamated into one bargaining unit for collective bargaining purposes.

This regrouping of the paramedical associations would mean that there would be five collective bargaining units: (1) The Canadian Union of Public Employees, (2) Building Service Employees Union, (3) Alberta Civil Service Association, (4) Alberta Association of Registered Nurses, and (5) the suggested amalgamated employees association. Such a grouping of employees would facilitate bargaining and would enable management to

spend more time in other hospital activities.

Notwithstanding the benefits that would accrue from such an innovation, there are a number of associated costs. Primarily, the creation of such a large bargaining unit would definitely increase the social consequences of a work stoppage or slowdown in the event of a bargaining impass. This suggestion of such a large employee group would also create an ever widening cartel for the paramedical groups who could, under such an arrangement, demand very significant wage increases.

It has also been noted in this study that there has been a progressive shift in collective bargaining responsibility from the local hospital board to the Alberta Hospital Association. It can be argued that in the hospital industry where employer–employee relationships and financing are basically similar in each of the member hospitals and where strong employee organizations have evolved, there is a need for a strong central employers' association.

The arguments in favour of multi-employer bargaining under the auspices of the Alberta Hospital Association are listed as follows:

(a) The effective elimination of "whipsawing," i.e., a union extracting a contract with large gains for the members from one hospital and using this as a wedge to obtain a similar contract throughout the hospital industry.

(b) The determination of a wage scale that will be related to standardized job descriptions for all hospitals in the Province.

(c) Pooling of knowledge and skills of negotiators which would be particularly beneficial to the small hospitals that cannot afford a personnel director.

There are a number of problems, however, with using the Hospital Association as the employee representative in collective bargaining. First, there could be a loss of initiative on the part of the individual hospital board. The board would feel that collective bargaining for their employees was being carried out by the Hospital Association, and as a consequence, they would bear no responsibility for it. Secondly, although group negotiations could be effectively handled by the Hospital Association, the area of bargaining on fringe benefits would be difficult. Specialized local issues would have to be negotiated outside the Master contract and would require considerable research on a regional basis to determine what was equitable. Finally, association bargaining would only be as strong as its weakest link. The party responsible for association bargaining would have to insure that all hospital boards would be willing to participate to the conclusion of the Master contract.

III. RECOMMENDATIONS

This paper concludes by recommending three areas for future research. The need for this research is borne out by the fact that there is no reliable information on these areas.

The first recommendation relates to the role of the Provincial Government in collective bargaining in the hospital industry. Briefly, in all matters relating to recruitment, training, promotion and employee supervision there are 156 employers of hospital personnel in Alberta--namely, the Local Hospital Boards. On the other hand, in matters relating to the expenditures on wages and other employee benefits there is a very close relationship that is necessary between hospital boards and the Province. This observation is in accordance with the respective responsibilities of the local hospital boards and the Alberta Government as outlined in Chapter II. Since the Province cannot delegate its financial decision making authority to the hospitals, hospital management cannot by itself provide adequate representation at the bargaining table.

The central issue that requires debate is--should the Provincial Government become directly involved in collective bargaining in the hospital industry or not? If the decision is to enter the bargaining field--what should be the nature and the methods and means of carrying it out? Further, what are the implications of such intervention for the system of labour management relations? These issues, it is recommended, must be investigated in light of the present crisis hospital boards are in with respect to meeting salary demands.

The traditional contacts between the public authorities, employers and unions have been limited in practice to times of labour management

conflict. Government agencies have then assumed the role of arbitrator or conciliator. Although these practices are quite consistent with the accepted methods of action in the Canadian system of industrial relations, it must be recognized that the government is assuming the role of employer for ever-increasing numbers of employees. It is necessary, therefore, to recognize that governments can no longer limit their action to regulating from a distance, the negotiations between two parties and to acting solely as the counterweight in the balance of strength between employers and employees. The idea of the freedom of the individual must be balanced by that of the community as a whole.

Certainly there are real costs in implementing such a system. The Provincial Government historically has not been a pricer of goods and services. The impact of government observers at the bargaining table could be detrimental in that any gains or losses incurred in the contract would be widely copies by industry in general. In addition, individual hospital boards might conclude that their role as community representatives was being diluted by the Government. Notwithstanding these costs, it is imparative that sound research be undertaken to thoroughly investigate the role of the Provincial Government in hospital labour negotiations.

The second area recommended for further research is on the effects that unionization have on the cost of hospital care. Although the percentage of employees unionized in Canada has changed very little over the last ten years, the hospital industry has not remained quite as static. This suggested

increase in the proportion of unionized hospital employees seems to be associated with a rapid escalation in salaries and wages. What is not clearly understood however, is the precise relationship between unionization and hospital costs. What is required is an empirical analysis of the question in order to predict the effects that a newly introduced labour group will have on hospital operating costs.

The third and final area recommended for further study relates to the development of productivity standards for the various types of hospital employees. It was noted during the course of this study, that salary settlements for paramedical associations were determined in relation to what nurses were being paid. This suggests that there is very little quantitative relationship between the tasks paramedical groups perform and their rates of pay. Further, since over 67 per cent - $90,000,000. - was spent in 1969 on hospital labour, it is absolutely essential that employers determine what tasks an employee can reasonably perform in an 8-hour period and how much this service is worth.[1]

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[1] In Chapter II, a breakdown of the per patient day cost of hospitalization was given in terms of general services cost and patient services' cost. It was noted that $20.65 or approximately 40 per cent of the patient day cost was spent in the "hotel" side of the hospital. Since industry in general has spent years developing industrial standards for measuring such activities as laundering and housekeeping, it would appear that hospitals can begin immediately to explore application of these techniques to their "hotel" operation. The patient services area which includes nursing, lab and X-ray, etc., are somewhat unique operations to the health industry. The task of measuring output in these areas presents some difficulties, however it is clear that attempts have to be made to introduce the appropriate sets of measurements and techniques required to correct the existing situation.

In conclusion, since unionization and collective bargaining are of recent origin in the Alberta hospital industry, management has the opportunity to initiate modern personnel practices and develop productivity standards for all classes of hospital employees. Instead of constituting a threat to the hospitals, responsible unionism can result in benefits to the hospital, the patient and to the employee. What is required is that the hospital employees, the boards, and the government cooperate in the expansion of the labour relations system in the Alberta hospital industry.

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APPENDICES

APPENDIX I

APPENDIX I

THE ENACTMENTS OF THE ALBERTA DEPARTMENT OF HEALTH (1969)

The Alberta Hospitals Act

The Alberta Hospital Association Act

The Cancer Treatment and Prevention Act

The Chartered Physiotherapists Act

The Chiropractic Profession Act

The Dental Association Act

The Dental Auxiliaries Act

The Dental Technicians Act

The Health Unit Act

The Marriage Act

The Mental Health Act

The Medical Profession Act

The Nursing Aides Act

The Naturopathy Act

The Nursing Service Act

The Nursing Homes Act

The Optometry Act

The Ophthalmic Dispensers Act

The Podiatry Act

The Pharmaceutical Association Act

The Provincial General Hospital Act

The Psychiatric Nurses Association Act

The Psychiatric Nurses Association Act

The Psychologists Act

The Public Health Act

The Radiological Technicians Act

The Registered Dietitians Association Act

The Registered Nurses Act

The University of Alberta Hospital Act

APPENDIX II

DEFINITION OF HOSPITALS IN ALBERTA

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1. (1) Membership in the Alberta Hospital Association may be granted to hospitals which are approved pursuant to the Alberta Hospitals Act, nursing homes, operating pursuant to the Nursing Homes Act, and to such other hospitals, institutions or organizations as may be approved for membership by the Board of Directors. Members of the Association shall be classified by the Board of Directors as follows:

(a) ACTIVE MEMBERS:

Type I	General hospitals: shall include hospitals operating in Alberta that care primarily for patients with conditions normally requiring a comparatively short stay.
Type II	Auxiliary hospitals: shall include hospitals operating in Alberta that care primarily for patients with conditions normally requiring a comparatively long stay.
Type III	Federal hospitals: shall include hospitals located in Alberta which are operated by Departments of the Government of Canada.
Type IV	Extra-provincial hospitals: shall include hospitals which are not located within the boundaries of the Province of Alberta.
Type V	New hospitals: shall include hospitals which are not yet operating and which are in the planning or construction stage.

(c) ACTIVE MEMBERS: (continued)

Type VI Contract nursing homes: shall include nursing homes under contract with the Government of Alberta.

Type VII Other: shall include such other institutions as are approved for active membership by the Board of Directors.

Source: Bylaws Alberta Hospital Association

APPENDIX III

ALBERTA ASSOCIATION OF REGISTERED NURSES

(A.A.R.N.) - COLLECTIVE BARGAINING

APPENDIX III

ALBERTA ASSOCIATION OF REGISTERED NURSES (A.A.R.N.) - COLLECTIVE BARGAINING

In 1962, as a result of nurses' complaints about difficulties in employer-employee relations, a resolution was passed at the annual meeting of the A.A.R.N., that when and wherever three or more nurses were employed, a staff association be formed. This association was to be recognized by administration of the respective hospitals and should provide for a voice for nurses to administration and vice versa.

In 1964, when the A.A.R.N. presented recommendations for an increase of $60.00 over the salary of $300.00 as a starting salary for a general duty graduate nurse, negotiations were not successful. A compromise was finally arrived at however, with the A.A.R.N. accepting $330.00 as a starting salary.

As a result of the breakdown in negotiations in 1964, in 1965 for the first time in the history of Alberta, a hospital staff nurses association was certified as a bargaining unit under the Labour Act. This certification at the Calgary General Hospital was quickly followed by certification of staff nurses associations in a few other major Alberta hospitals.

A conciliation board award handed down June 6, 1966, also made hospital history in Alberta. It marked two important precedents: (1) it was the first collective bargaining under the Alberta Labour Act, carried out by the Alberta Hospital Association and the A.A.R.N. on behalf of their respective members, and (2) it was the first time nurses and employers had, in the process of negotiations, gone from collective bargaining through the stages of conciliation to a conciliation board.[1]

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[1]Interview with the Alberta Association of Registered Nurses and George P. Van, "Nurse Group Bargaining Gains Around in Alberta." Hospital Administration in Canada, 9 (February, 1967), p. 37.

APPENDIX IV

PARAMEDICAL ASSOCIATIONS AND COLLECTIVE BARGAINING WITH THE ALBERTA HOSPITAL ASSOCIATION

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PARAMEDICAL ASSOCIATIONS AND COLLECTIVE BARGAINING WITH THE ALBERTA HOSPITAL ASSOCIATION

Five paramedical associations responded to the questions on what procedures they used in negotiating salaries and working conditions and on how effective these procedures are

The Canadian Society of Radiological Technicians stated that salary scales and working conditions are negotiated by the C.S.R.T. Alberta Division and the Alberta Hospital Association. Each year the C.S.R.T. prepares a brief which is submitted to the A.H.A. Both groups set up a negotiating team who meet until an agreement is reached. This system has been working well for both groups and few changes are anticipated.

According to the Alberta Registered Dietitians Association a salary committee of the A.R.D.A. negotiates directly with the Alberta Hospital Association. Once an agreement has been reached between the A.R.D.A. and the A.H.A. the individual hospital dietitians negotiate with their administration. After the hurdle of reaching an agreement between A.H.A. and A.R.D.A. has been overcome, the final step--Dietitian versus her hospital administration--usually proceeds rapidly and without difficulty. The only

problem with this system is that it is felt to be too time consuming according to A.R.D.A. officials.

The Alberta Association of Medical Librarians through an appointed salary committee sets meetings with A.H.A. to establish salary levels. These salary scales are then submitted as recommendations by A.H.A. to their member hospitals to be used for local bargaining purposes. Hospitals are not legally bound to abide by these recommendations though most administrators use them as guidelines when setting salaries.

The Alberta Society of Dietary Technicians held their first series of negotiations with the Alberta Hospital Association in January, 1970. According to Society officials this procedure worked very well and will be continued in the future.

The Canadian Society of Inhalation Therapy Technicians stated that salary scales and working conditions are negotiated by the C.S.I.T.T. Alberta Division and the Alberta Hospital Association. Each year the C.S.I.T.T. prepares a brief which is submitted to the A.H.A. Both groups set up a negotiating team who meet until an agreement is reached. Although not all hospitals employing inhalation therapists recognize the resulting agreement there have been no serious confrontations to date.